

SFY 2025

WYOMING MEDICAID

Annual Report



Wyoming
Department
of Health

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Stefan Johansson
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Mark Gordon
Governor

February 9, 2026

Dear Medicaid Providers, Members, Stakeholders, and Wyoming Residents:

I am proud to present to you the latest edition of the Wyoming Medicaid Annual Report for State Fiscal Year 2025 (SFY 2025) that covers expenditures and enrollment occurring July 1, 2024 to June 30, 2025. During SFY 2025, we improved provider recruitment, especially in services such as home health, dentistry and orthodontia where a lower percentage of providers have historically participated.

In addition, Wyoming Medicaid has been focused on addressing a backlog of eligibility renewals for Medicaid long-term care members. Our team has been laser focused on ensuring Wyomingites are determined eligible or ineligible in a timely, accurate, and transparent manner. We have made a number of practical changes in SFY 2025 as well as shifting additional staffing to this function. Our team is actively researching deeper policy and technology changes to automate renewals and reduce unnecessary barriers.

Additional Medicaid highlights:

- Maternity care and emergency medical services had in-depth workgroups and major studies completed, which prepared Wyoming well for the Rural Health Transformation process.
- Increased reimbursement rates for home health and maternity related procedure codes by shifting funding from other services.
- Wyoming had excellent 2025 cycle results for claims processing and Medicaid eligibility determinations compared to the national Payment Error Rate Monitoring (PERM) national averages.
- Launch of a new Fraud, Waste and Abuse Case Management and Detection technology system.

This report is the primary annual resource for trusted and verified information about the Wyoming Medicaid and M-CHIP programs. Questions may be directed to the Wyoming Department of Health's Division of Healthcare Financing at (307) 777-7531 or by email at wdh-medicaid-communications@wyo.gov.

Sincerely,

A handwritten signature in blue ink that reads "Jesse Springer".

Jesse Springer, State Medicaid Agent

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SFY 2025

MEDICAID AT A GLANCE

EXPENDITURES

\$667,179,184

paid to **3,519** providers with over **28,178** providers actively enrolled at any point during SFY 2025

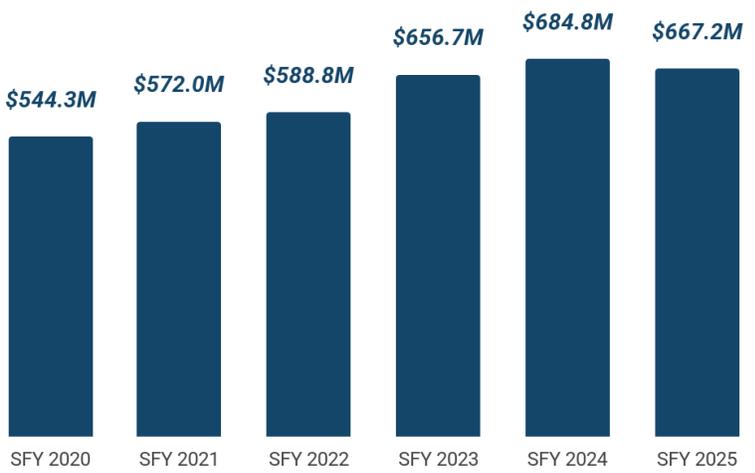


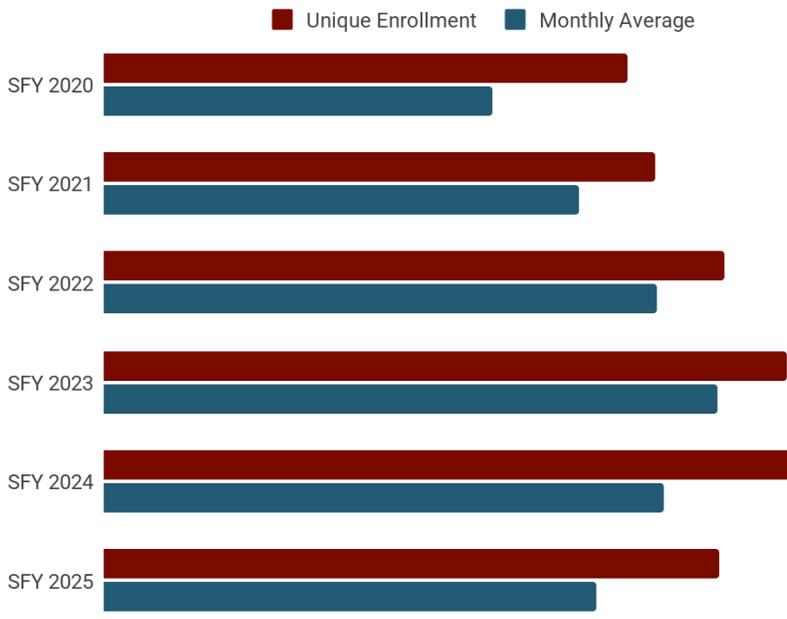
Figure 1. Medicaid Expenditure History

15.2%
Wyoming residents enrolled in Medicaid

Months of average enrollment per member:
10.4

50%
of Members reside in Fremont, Natrona, and Laramie counties

% of members that are children under age 21:
62.2%



ENROLLMENT

89,298

Medicaid members enrolled at any point during the SFY with **71,304** enrolled each month on average

Figure 2. Medicaid Enrollment History: Monthly Average and Unique Enrollment

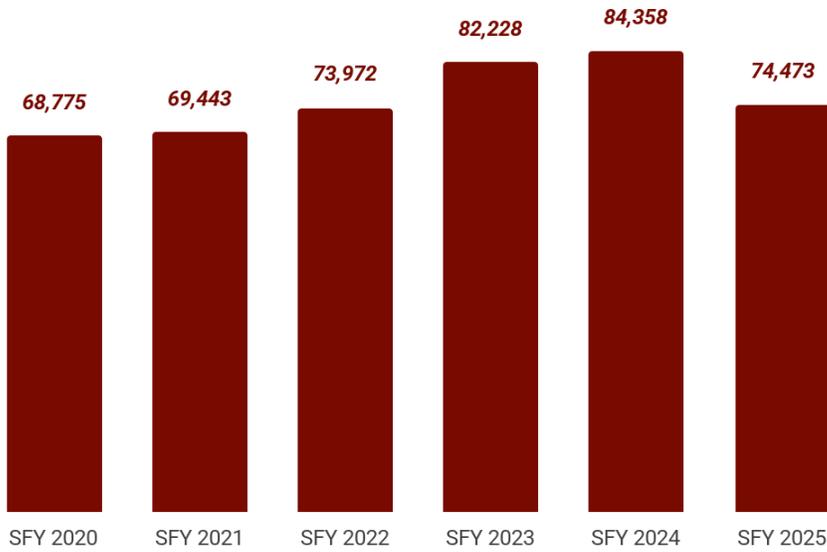


Figure 3. Medicaid Recipient History

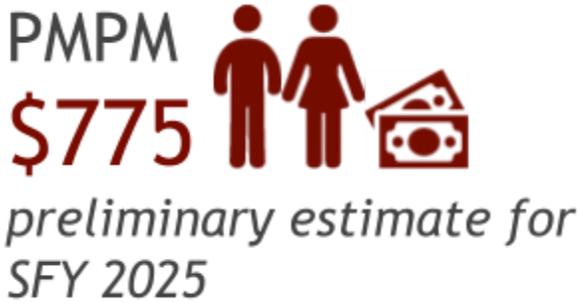


Figure 4. Medicaid Per Member Per Month (PMPM) History

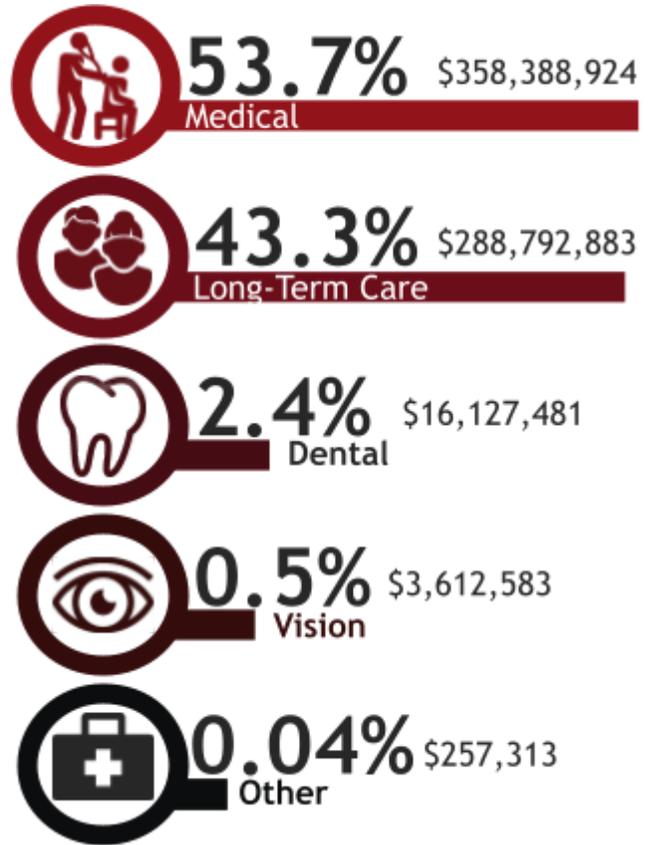


Figure 5. Percent of Total Expenditures by Type

WY MEDICAID BACKGROUND

Wyoming Medicaid is a joint federal and state government program that pays for medical care for low-income individuals and families. Medicaid eligibility is based on residency, citizenship and health status, age, social security eligibility as verified by social security number, family income, and, to a lesser extent, resources, and/or health care needs. The Division of Healthcare Financing (DHCF) within the Wyoming Department of Health (WDH) is the state-appointed entity for the administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services.

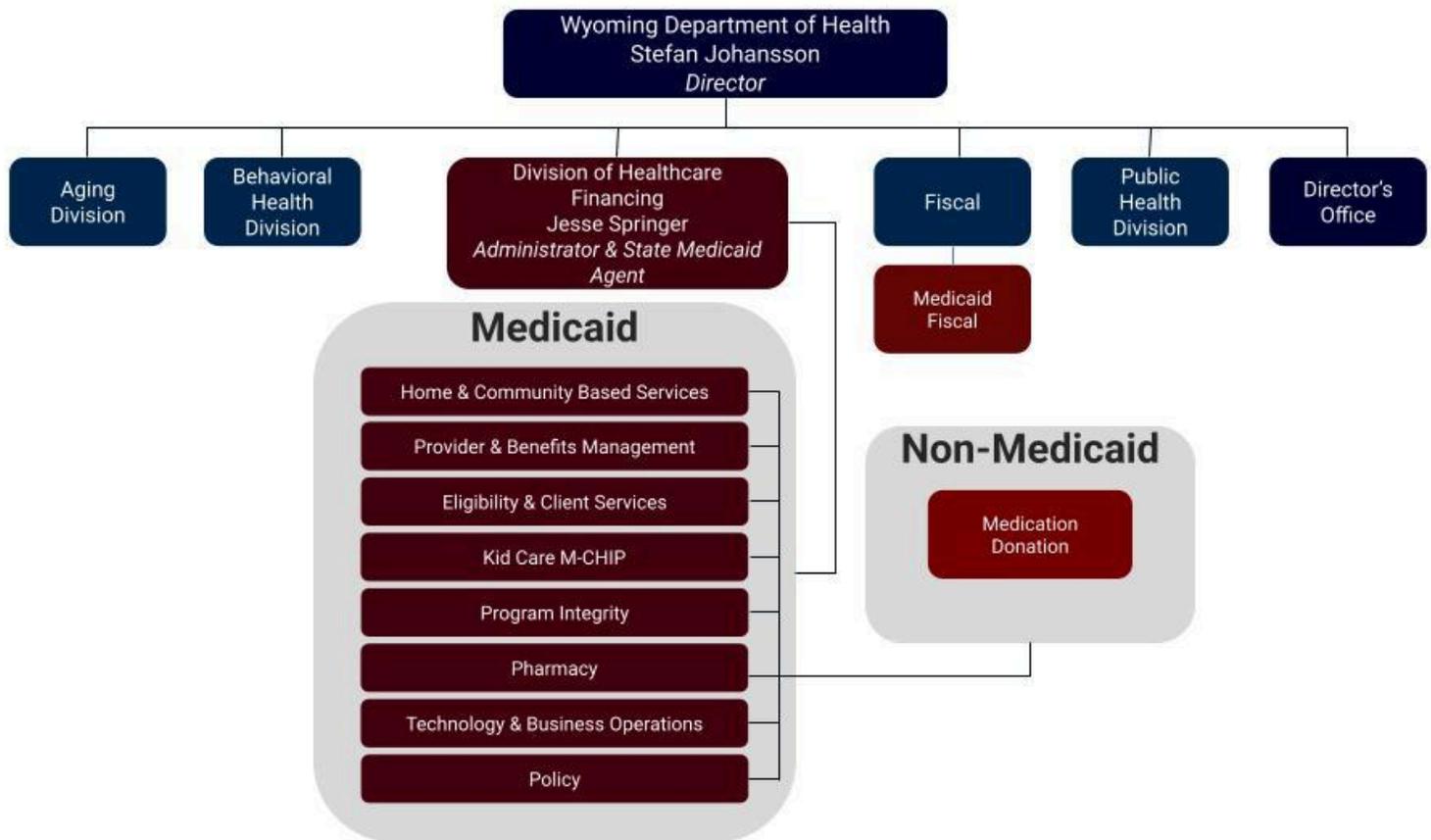


Figure 6. Wyoming Department of Health Organization Chart



FINANCIALS & FUNDING

Enrolled providers have one year from the date of service to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS), which includes pharmacy claims point of sale processing system and a separate system for all other claim types. This Annual Report focuses on the members enrolled during SFY 2025 and claims paid during SFY 2025, regardless of when service was rendered.

Table 1. Division of Healthcare Financing Expenditures for SFY 2025

Medicaid Expenditures (in Millions)	
Annual Report Benefit Expenditures (this report)	\$667.2
Medicaid Administration	\$60.5
Member Non-Emergency Transportation	\$0.3
Nursing Facilities Supplemental Payments	\$33.5
Hospital Supplemental Payments	\$103.4
Medicare Buy-In	\$24.6
Medicare Clawback (Part D)	\$19.9
Medicaid One-Time Capital Expenses for New Technology Systems (Medicaid Modules, HIE, Other)	\$11.8
Other	-\$7.5
Subtotal Medicaid Expenditures	\$913.7
Drug Rebates	-\$31.0
Total Medicaid Expenditures	\$882.7
Non-Medicaid Expenditures (in Millions)	
State Only Foster Care & General Fund Foster Care (Court Orders)	\$1.8
Supplemental Security Income Payments	\$0.8
State Only Other	\$0.6
Total Non-Medicaid Expenditures	\$3.2
Total Division of Healthcare Financing Expenditures	\$885.9

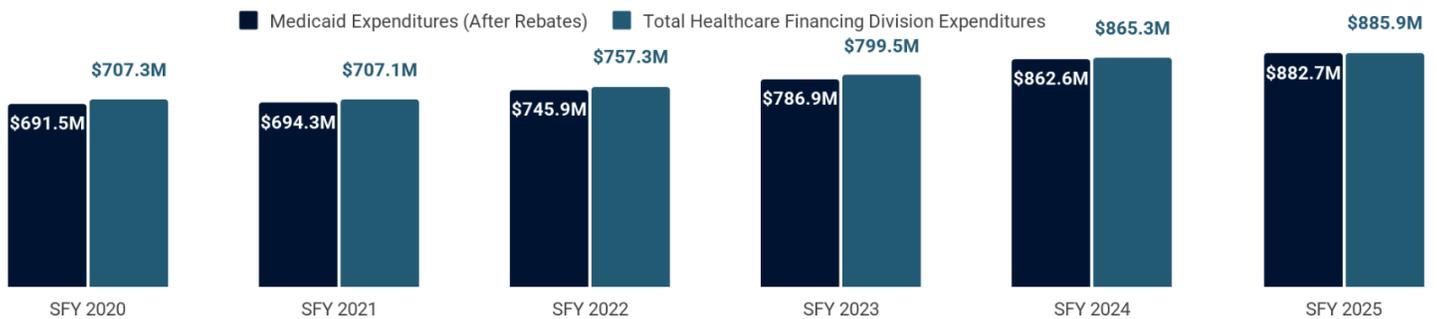


Figure 7. Health Care Financing Expenditure History

WYOMING MEDICAID FUNDING

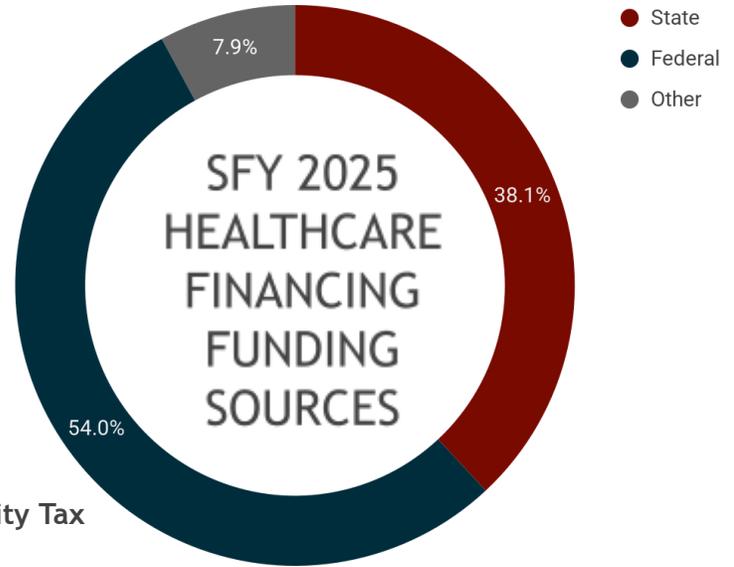
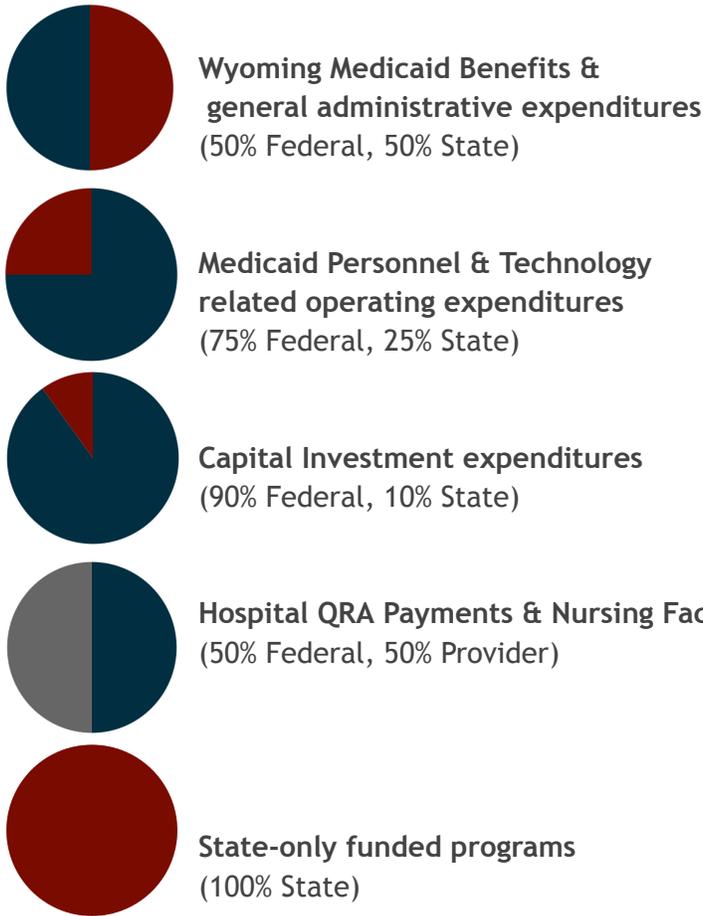


Figure 8. SFY 2025 DHCF Funding Sources

Figure 9. Medicaid Funding Breakdown

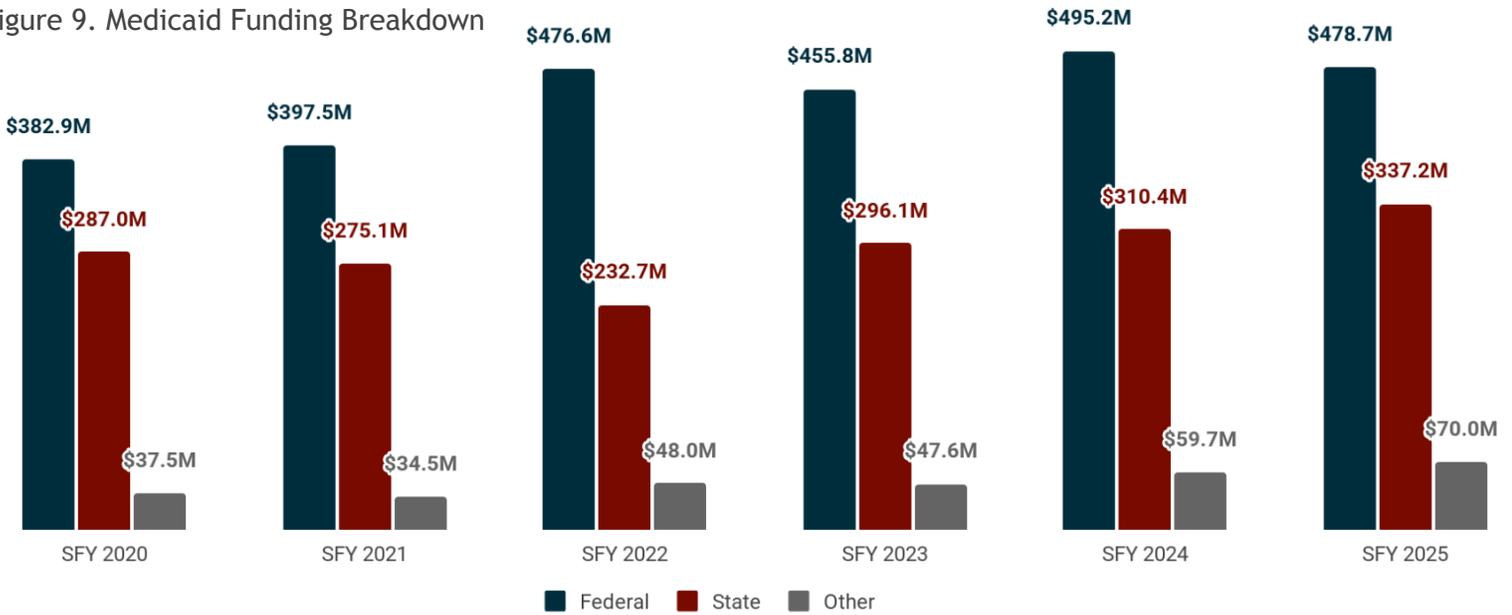


Figure 10. Division of Healthcare Financing Funding History (in millions)



ADVISORY GROUPS

Table 2. Wyoming Medicaid Advisory Groups and Committees

Advisory Group	Members	Description
Dental Advisory Group (DAG)	Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Acentra.	Represents a wide range of interests, experience, dental specialties and various areas of the state, while advising Medicaid regarding administration of the dental program.
Developmental Disability Advisory Council (DDAC)	Self advocates, legally authorized representatives, providers, case managers, Wyoming Provider Association representation, members from the Governor's Council on DD, Department of Education, Department of Vocational Rehabilitation, WIND, Department of Family Services, Protection and Advocacy.	The DDAC advises the Department on rules, policies and procedures related to waiver programs and the statewide service delivery system for people with developmental disabilities and acquired brain injuries.
Long-Term Care Advisory Group	Nursing Home Association leadership, five nursing home providers, a home health provider, a hospice provider, an assisted living provider, a Community Choices waiver case manager, and an Independent Living Center representative.	Focuses on issues and recommendations with institutional and community-based long term care providers.
Medical Advisory Group (MAG)	Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners.	Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues.
Pharmacy & Therapeutics Committee (P&T)	Six physicians, five pharmacists, one allied health professional.	Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid.
Tribal Leadership Advisory Group	Tribal Business Council members, leadership and executives from tribal health clinics and Indian Health Services, long-term care providers, and representatives from all Wyoming Department of Health divisions.	Focuses on new and upcoming issues within the healthcare industry, consultation with the Tribal leaders, updates from facilities, and work to develop solutions and programs to decrease barriers for this group.



PROGRAM INTEGRITY & THIRD PARTY LIABILITY

Table 3. Program Integrity & Third-Party Liability Medicaid Cost Avoidance and Recoveries

Program Area	Description	Amount Identified or Recovered
Program Integrity	Process of reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing.	\$1,645,257
Third Party Liability Recoveries	Recovered funds from other obligated parties: Medicare, health insurance, workers' compensation, casualty insurance, or spouse/parent court-ordered health insurance.	\$2,961,556
Third Party Liability Cost Avoidance	Estimates State costs avoided when third-party liability (TPL) denies claims upfront. Based on providers' billed charges, not final Medicaid payment, as TPL-denied claims aren't fully adjudicated, meaning the estimate may be inflated. Includes claims paid when TPL is reported on a claim. Cost savings are determined by the Medicaid allowed amount once claims are fully processed. Medicaid is currently reviewing alternate methods for determining cost avoidance.	\$24,760,202
Estate Recoveries	Funds recovered from a client's probate estate and/or a client's real or personal property interest at the time of death, including assets conveyed to a survivor, heir, or assigned via joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.	\$4,632,261
Credit Balances	Moneys recovered from providers whose credits (i.e., take-backs or adjustments) exceed their debits (pay-outs or paid claims).	\$0
Total Recovered Dollars (excluding Cost Avoidance)		\$9,239,074
Total Recovered Dollars (including Cost Avoidance)		\$33,999,276

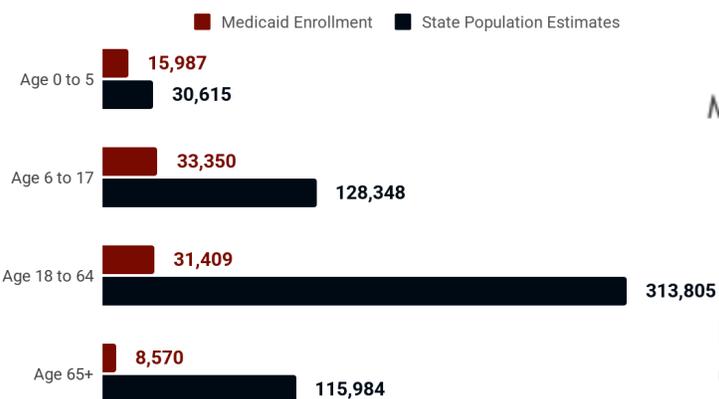
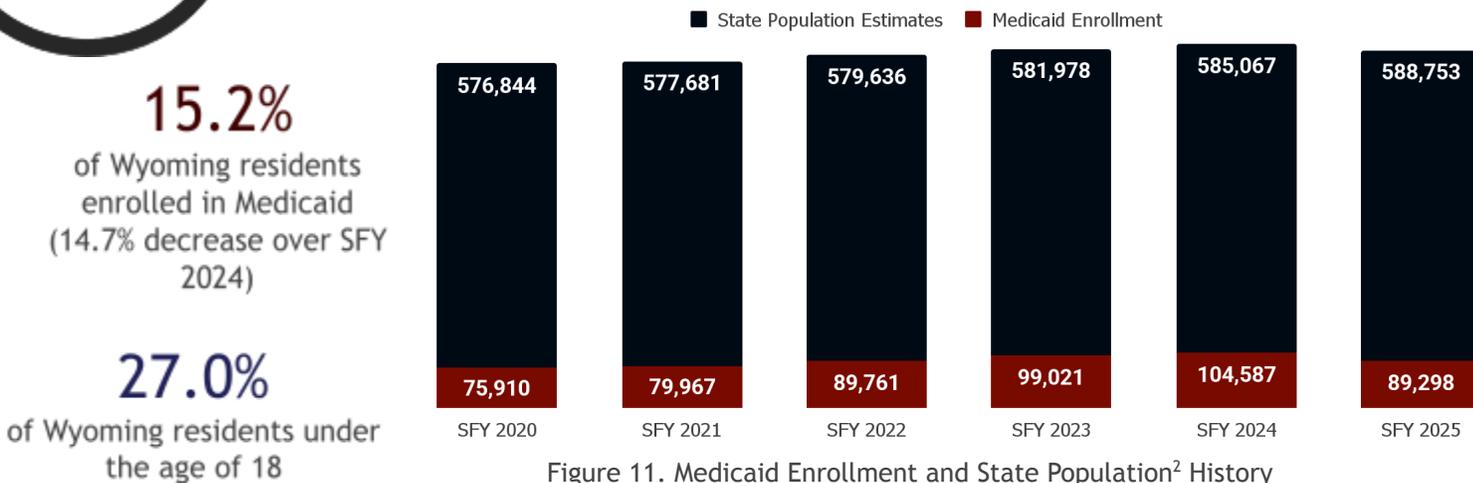


Figure 12. SFY 2025 State Population & Medicaid Enrollment Age Bands

17.5%
Medicaid Enrollment Increase
(from 2020 to 2025)

1.9%
Increase in State Population
(from SFY 2020 to SFY 2025)

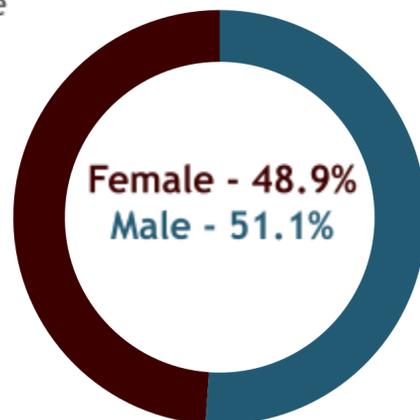


Figure 13. SFY 2025 State Population Gender Percentages

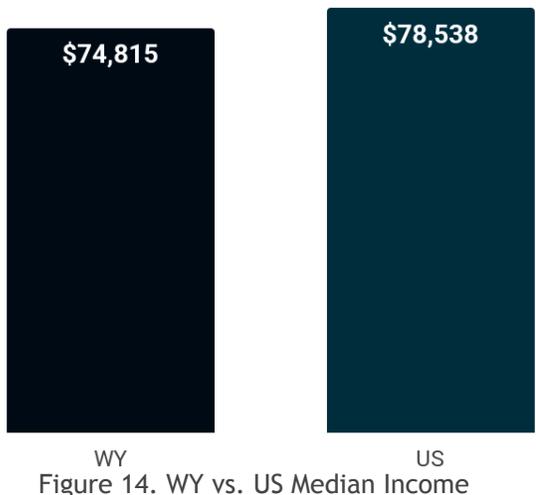


Figure 14. WY vs. US Median Income

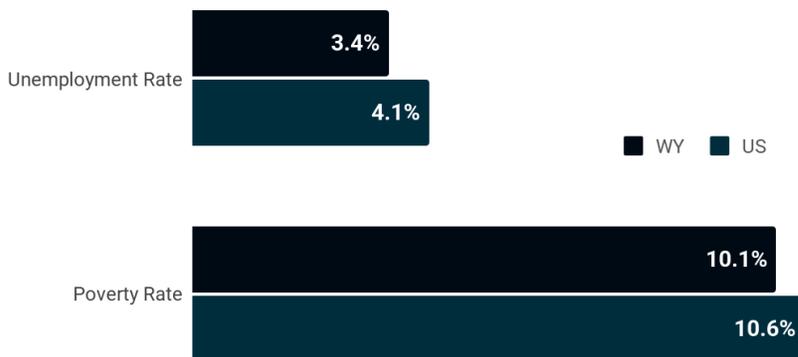


Figure 15. WY vs. US Unemployment and Poverty Rates

¹ US Census Bureau: <https://doe.state.wy.us/lmi/news.htm>, <https://www.census.gov/quickfacts/fact/table/WY,US#>

² 2025 forecasted population information prepared by the Wyoming Department of Administration & Information, Economic Analysis Division

HIGHLIGHTS & INITIATIVES



POLICY

- In June 2025, home health rates were increased to 70% of Medicare rates.
- In 2024, Wyoming Medicaid offered providers interested in joining the Patient Centered Medical Home (PCMH) program, but were not yet accredited, a lower PMPM rate of \$3 for 12 months. In SFY 2025, all interested PCMH clinics are accredited.
- Beginning in CY 2024, PCMH clinics have the opportunity to focus measures for children, adults, or both children and adults. PCMH measures were also updated at this time.



PROGRAM

- In an effort to retain and educate current PCMH clinics, a PCMH state-wide meeting was introduced annually. In April of 2025, the second annual PCMH Round-up conference was held in Casper. The purpose of this meeting is to bring all PCMH clinics together for networking as well as highlighting the successes of the program and particular participating providers.
- Children's mental and behavioral health screening of Applied Behavioral Analysis (ABA) became more accessible to members as a preventive service as opposed to only being available as a rehabilitative service. CMS approved a state plan amendment categorizing ABA as preventive service under Early Periodic Screening Diagnosis and Treatment (EPSDT) on October 31, 2024, effective on July 1, 2024.



TECHNOLOGY

- The WYFI system upgrade progress continues in SFY 2025, which started in August of 2023. The upgrade includes KPI Ninja Universe, Analytics and Population Health Solutions Dashboard, and the Amazon Web Services Cloud infrastructure and is expected to go live in SFY 2026.
- Production deployment of the upgraded Program Integrity (PI) system FWA2 (Fraud, Waste, and Abuse) went live in June 2025. Design and development of this system occurred from February 2024 through May 2025.

WYOMING INTEGRATED GENERATION SYSTEM (WINGS)



Figure 16. WINGS Project



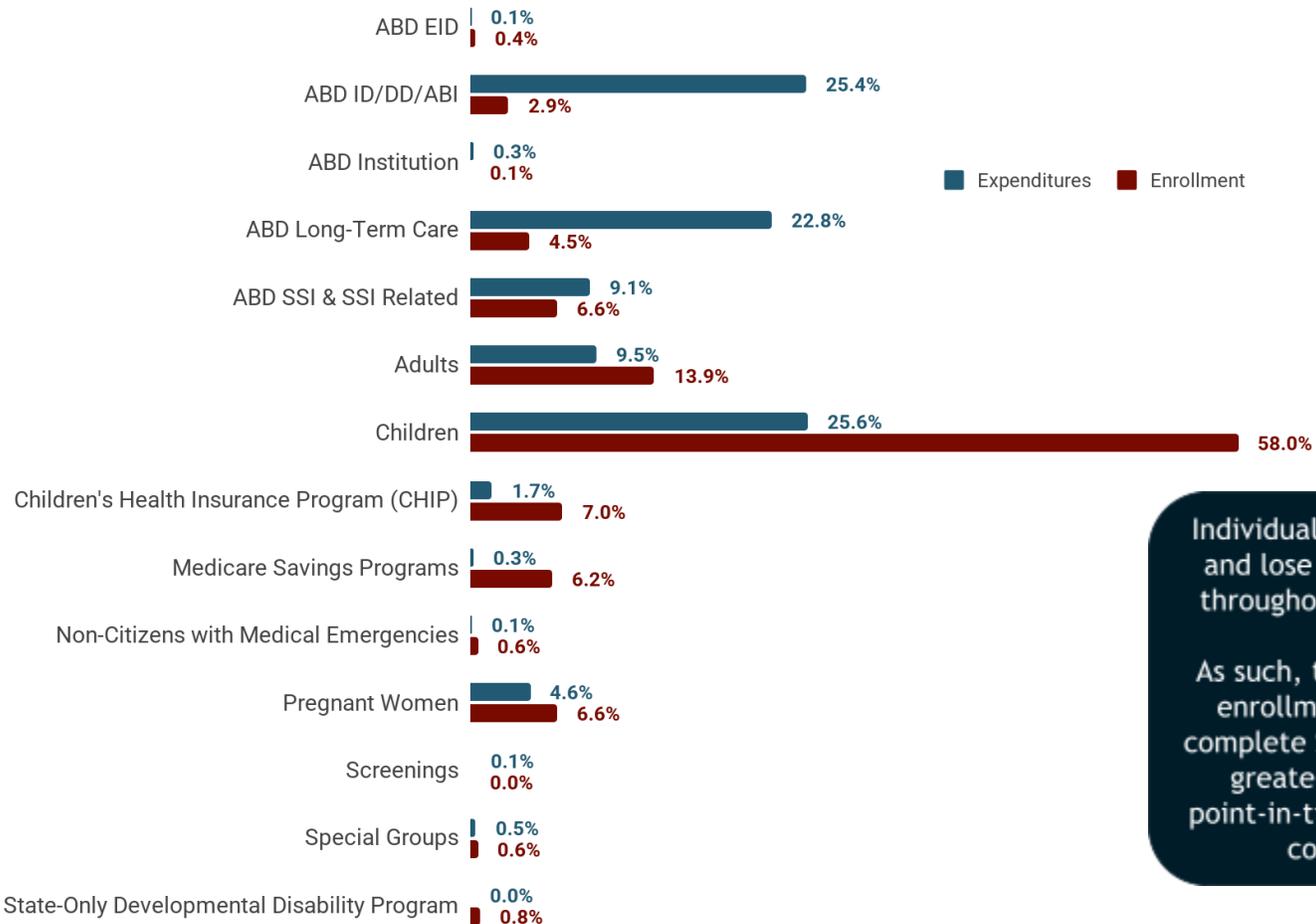
ELIGIBILITY CATEGORIES

For this report, Medicaid enrolled members are presented in 14 eligibility categories. Per Code of Federal Regulations, individuals qualify for Medicaid coverage based on Federal Poverty Level guidelines, Supplemental Security Income standards, or the 1996 Family Care income standard. This report does not constitute billing or coverage advice for members or providers. For comprehensive program information, please refer to the Provider Manual³ and the Member Handbook⁴.

- ◆ Age, Blind, or Disabled (ABD)
- ◆ Employed Individuals with Disabilities (EID)
- ◆ Individuals with Intellectual/Developmental Disabilities or Acquired Brain Injury (ID/DD/ABI)

- ◆ Institution
- ◆ Long-Term Care (LTC)
- ◆ Supplemental Security Income (SSI)
- ◆ Adults
- ◆ Children
- ◆ Children Health Insurance Plan (CHIP)

- ◆ Medicare Savings
- ◆ Non-Citizens with Medical Emergencies
- ◆ Pregnant Women
- ◆ Screenings
- ◆ Special Groups
- ◆ State-Only Developmental Disability Program



Individuals may gain and lose eligibility throughout the SFY. As such, the unique enrollment for a complete SFY may be greater than a point-in-time unique count

Figure 17. Enrolled members versus Expenditures by Eligibility Category

³ Provider Manual: <https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins>

⁴ Member Handbook: https://www.wyomingmedicaid.com/portal/Medicaid_Handbook

Table 4. Eligibility Category Summary

Eligibility Category	2025 Enrolled Members	% Change from SFY 2024	SFY 2025 Unique Recipients ⁵	% Change from SFY 2024	SFY 2025 Expenditures	% Change from SFY 2024
ABD EID	275	-35.0	298	-27.8	\$1,257,779	52.2
ABD ID/DD/ABI	3,102	2.2	3,148	2.3	\$181,644,789	4.5
ABD Institution	44	-26.7	47	-31.9	\$1,390,179	-33.2
ABD Long-Term Care	4,475	-4.2	4,874	-12.5	\$150,907,844	-3.4
ABD SSI & SSI Related	6,127	-11.9	5,620	-12.7	\$63,043,156	1.5
Adults	11,252	-22.6	9,337	-18.5	\$52,951,656	-19.0
Children	49,842	-17.7	42,142	-13.4	\$166,748,022	-4.7
Children's Health Insurance Program (CHIP)	7,851	7.5	6,205	19.4	\$14,029,039	22.0
Medicare Savings Programs	6,788	4.5	3,172	-5.2	\$1,760,156	-5.4
Non-Citizens with Medical Emergencies	376	-40.5	239	3.9	\$1,306,752	33.5
Pregnant Women	5,051	-26.7	5,236	-12.3	\$28,213,903	-9.9
Screenings	< 10	0.0	689	-1.3	\$578,800	-5.6
Special Groups	1,739	2.1	260	-16.9	\$3,347,108	5.7
Total	89,212	-14.7	74,473	-11.7	\$667,179,184	-2.6

Table 5. Enrollment History by Eligibility Category

Eligibility Category	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
ABD EID	328	326	336	363	423	275	-16.2
ABD ID/DD/ABI	2,470	2,512	2,611	2,695	3,034	3,102	25.6
ABD Institution	44	39	40	45	60	44	0.0
ABD Long-Term Care	4,798	4,746	4,660	4,609	4,670	4,475	-6.7
ABD SSI & SSI Related	6,459	6,384	6,722	6,937	6,955	6,127	-5.1
Adults	9,478	10,006	11,451	12,810	14,539	11,252	18.7
Children	41,589	44,014	50,319	56,560	60,528	49,842	19.8
Children's Health Insurance Program (CHIP)	3,809	3,911	--	4,314	7,304	7,851	106.1
Medicare Savings Programs	4,769	4,888	5,291	5,592	6,494	6,788	42.3
Non-Citizens with Medical Emergencies	156	188	318	465	632	376	141.0
Pregnant Women	3,225	3,496	4,585	5,548	6,894	5,051	56.6
Screenings	--	--	--	< 10	< 10	< 10	--
Special Groups	740	880	1,073	1,377	1,704	1,739	135.0
Total	75,910	79,967	89,761	99,021	104,587	89,212	17.5

⁵ This column displays a distinct count of recipients for each eligibility category as well as the total distinct count of recipients. Summing the recipients for each eligibility category will not match the total recipients as individuals may receive services under multiple eligibility categories throughout the SFY.

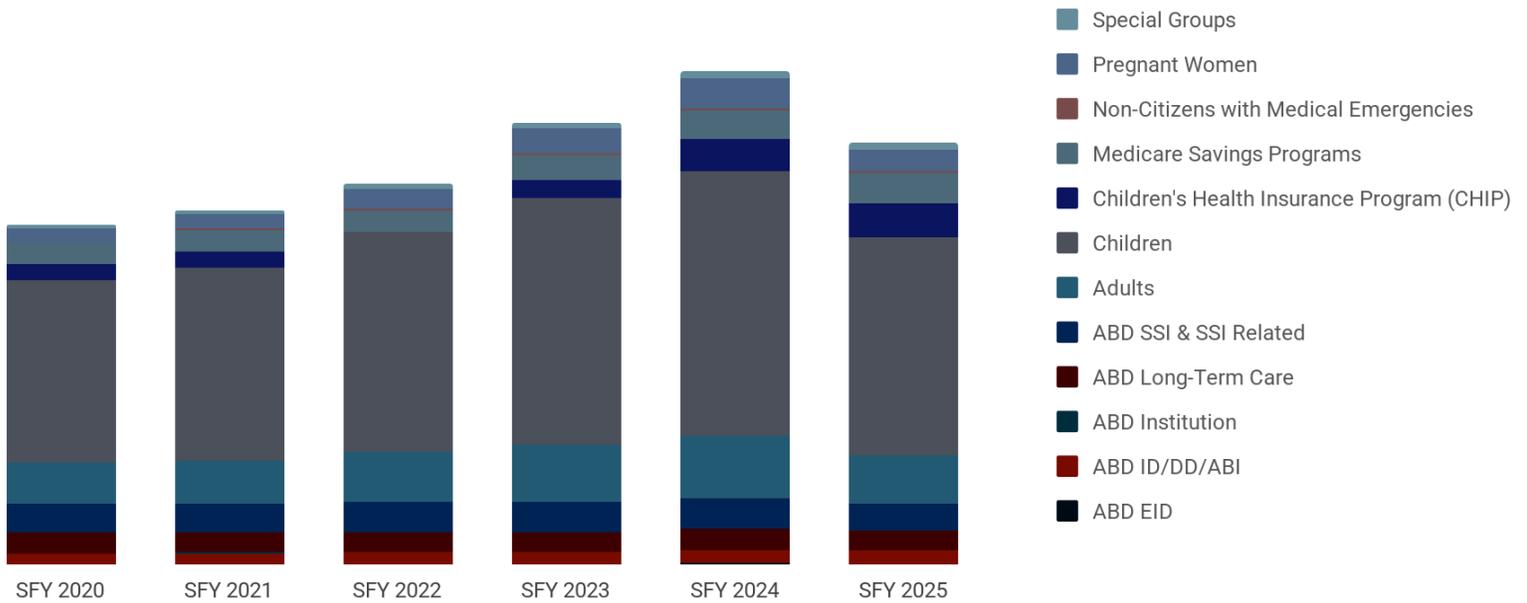


Figure 18. Enrollment History by Eligibility Category

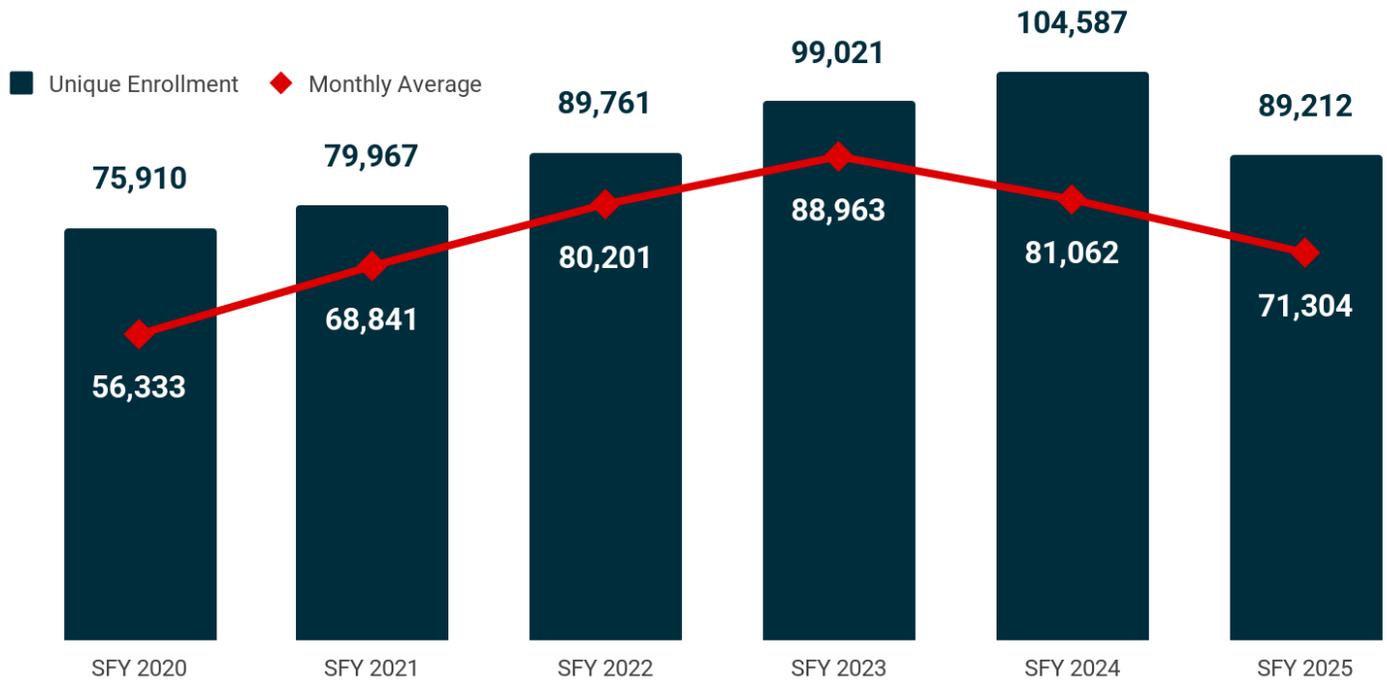


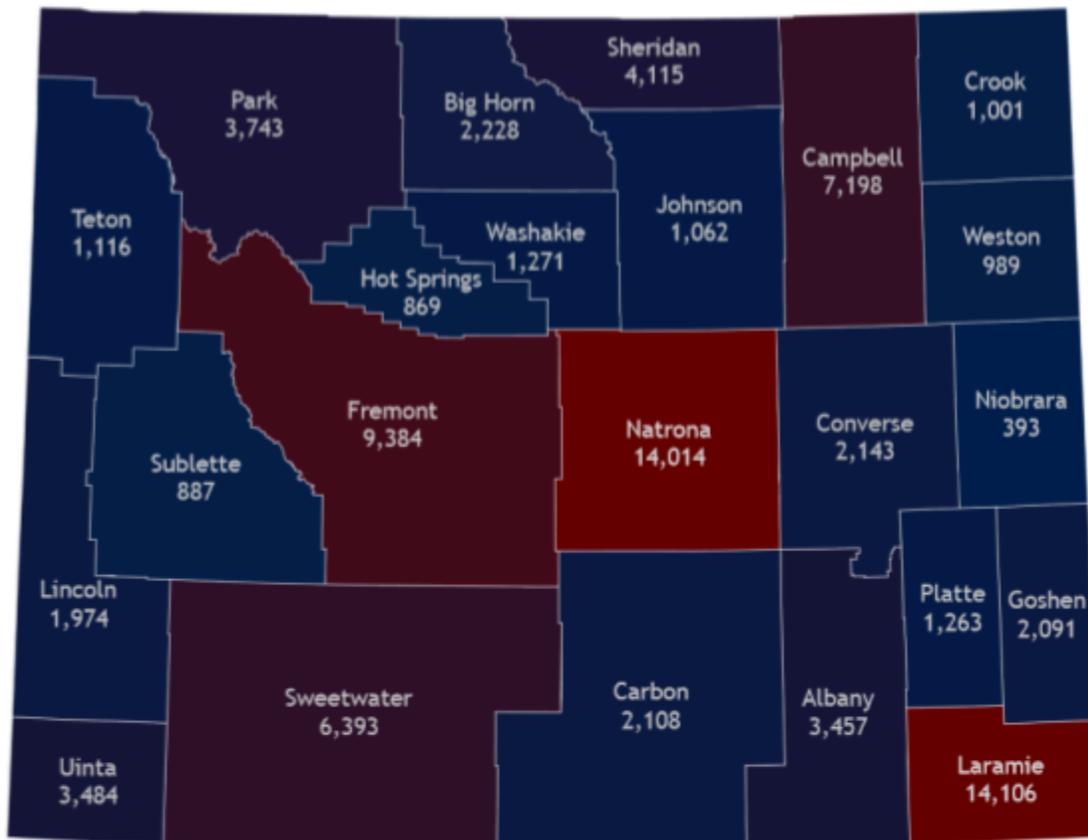
Figure 19. Medicaid Unique Enrollment and Monthly Average by SFY

Table 6. Change in Medicaid Enrollment

	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Unique Enrollment	75,910	79,967	89,761	99,021	104,587	89,212
% Change from Previous SFY	0.6	5.3	12.2	10.3	5.6	-14.7
Monthly Average Enrollment	56,333	68,841	80,201	88,963	81,062	71,304
% Change from Previous SFY	0.3	22.2	16.5	10.9	-8.9	-12.0
Average Length in Enrollment (months)	11.2	9.7	9.3	9.2	10.7	10.4

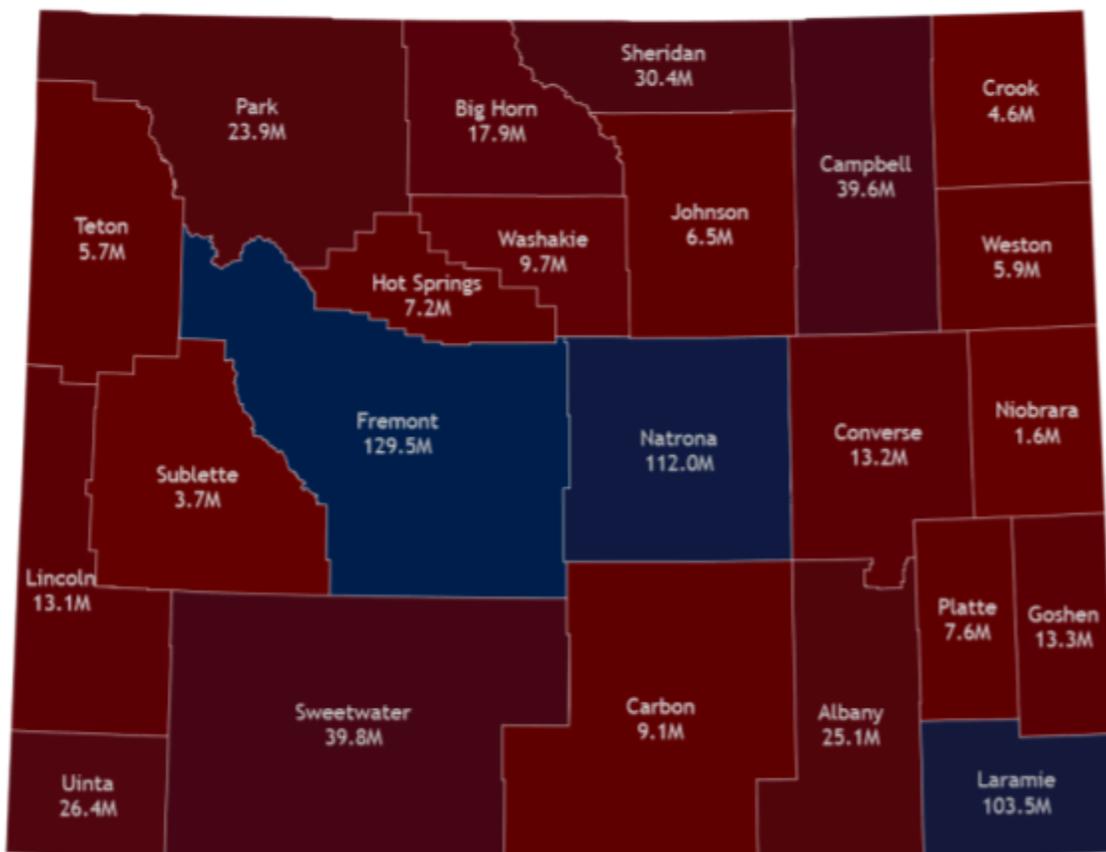
Member Count 393 14,106

Figure 20. Medicaid Enrollment by County



Expenditures 1.6M 129.5M

Figure 21. Medicaid Expenditures by County





EXPENDITURES

Table 7. Expenditure History by Eligibility Category

Eligibility Category	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
ABD EID	\$1,756,635	\$3,168,949	-\$261,818 ⁶	\$1,155,239	\$826,565	\$1,257,779	-28.4
ABD ID/DD/ABI	\$152,541,587	\$155,360,814	\$150,075,613	\$163,097,648	\$173,805,589	\$181,644,789	19.1
ABD Institution	\$1,239,234	\$4,139,118	\$1,342,101	\$2,358,667	\$2,079,554	\$1,390,179	12.2
ABD Long-Term Care	\$144,976,414	\$134,892,349	\$127,016,422	\$138,732,339	\$156,185,361	\$150,907,844	4.1
ABD SSI & SSI Related	\$54,412,195	\$56,186,651	\$62,657,716	\$64,664,701	\$62,092,349	\$63,043,156	15.9
Adults	\$37,137,296	\$52,267,090	\$58,987,335	\$70,185,525	\$65,364,828	\$52,951,656	42.6
Children	\$124,888,851	\$134,266,458	\$150,272,444	\$172,332,818	\$174,963,147	\$166,748,022	33.5
Children's Health Insurance Program (CHIP)	--	\$5,045,497	\$8,345,854	\$9,946,248	\$11,500,200	\$14,029,039	--
Gross Adjustments	\$680,047	-\$758,113	\$736,623	--	--	--	--
Medicare Savings Programs	\$1,743,633	\$1,831,726	\$1,894,439	\$2,248,566	\$1,860,701	\$1,760,156	0.9
Non-Citizens with Medical Emergencies	\$586,871	\$657,593	\$781,986	\$787,663	\$978,974	\$1,306,752	122.7
Pregnant Women	\$21,725,470	\$22,087,873	\$24,065,741	\$27,244,487	\$31,323,517	\$28,213,903	29.9
Screenings	\$762,114	\$524,863	\$485,026	\$782,407	\$613,079	\$578,800	-24.1
Special Groups	\$1,879,961	\$2,302,874	\$2,428,286	\$3,162,638	\$3,165,223	\$3,347,108	78.0
Total	\$544,330,310	\$571,973,741	\$588,827,770	\$656,698,947	\$684,759,086	\$667,179,184	22.6

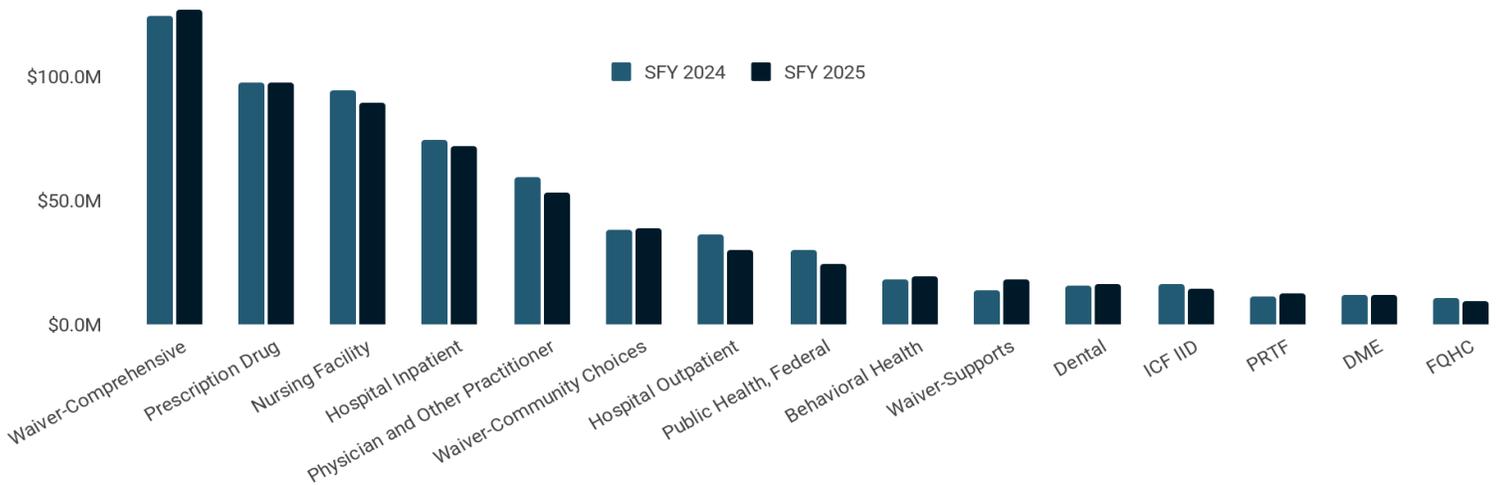


Figure 22. Comparison of Top Medicaid Services' Expenditures for SFY 2024 and SFY 2025

⁶ The negative expenditure number for the ABD EID (Aged, Blind, or Disabled Employed Individuals with Disabilities) is due to a large number of gross adjustments for this category meaning that the Agency received more money than it paid out.



Figure 23. Medicaid Expenditures Benefit History

Table 8. Medicaid Expenditure History by Service Type

Service Area	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Medical	\$270,898,127	\$301,361,208	\$331,502,228	\$374,833,864	\$376,828,831	\$358,388,924	32.3
Long-Term Care	\$260,294,311	\$254,197,341	\$240,641,530	\$263,394,718	\$287,891,554	\$288,792,883	10.9
Dental	\$9,893,628	\$12,498,782	\$12,800,061	\$14,279,555	\$16,048,784	\$16,127,481	63.0
Other	\$267,174	\$189,650	\$244,521	\$309,435	\$293,203	\$257,313	-3.7
Vision	\$2,977,070	\$3,726,760	\$3,639,429	\$3,881,375	\$3,696,713	\$3,612,583	21.3

■ SFY 2024 ■ SFY 2025

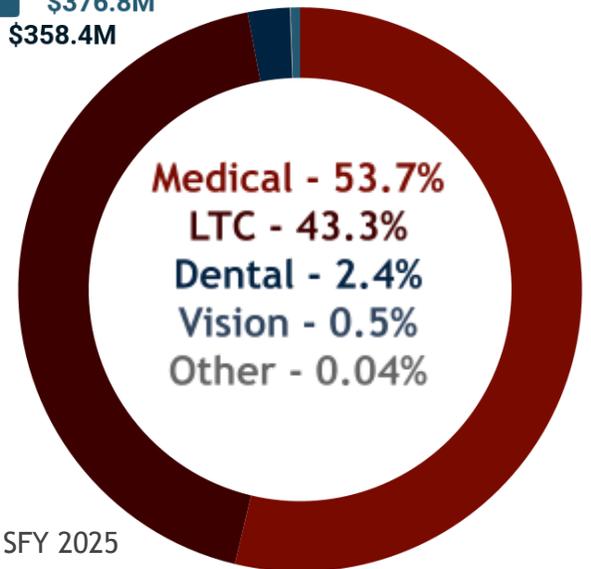
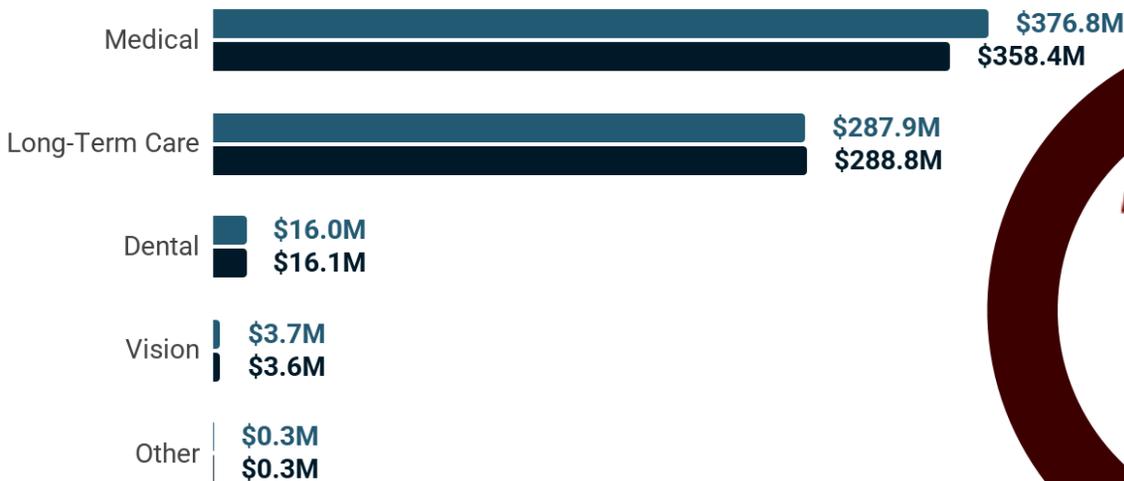


Figure 24. Comparison of Expenditures by Service Type for SFY 2024 and SFY 2025

Figure 25. SFY 2025 Expenditures by Service Type



RECIPIENTS

Table 9. Unique Recipient History by Eligibility Category⁷

Eligibility Category	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
ABD EID	382	320	318	358	413	298	-22.0
ABD ID/DD/ABI	2,655	2,633	2,659	2,736	3,078	3,148	18.6
ABD Institution	76	71	57	57	69	47	-38.2
ABD Long-Term Care	5,830	5,160	4,977	5,300	5,572	4,874	-16.4
ABD SSI & SSI Related	6,087	5,828	5,949	6,348	6,435	5,620	-7.7
Adults	8,098	8,308	9,083	10,406	11,454	9,337	15.3
Children	39,420	39,256	42,216	47,415	48,672	42,142	6.9
Children's Health Insurance Program (CHIP)	--	2,939	3,394	3,576	5,197	6,205	--
Gross Adjustments	277	93	44	--	--	--	--
Medicare Savings Programs	2,938	2,717	2,687	3,061	3,345	3,172	8.0
Non-Citizens with Medical Emergencies	140	124	154	234	230	239	70.7
Pregnant Women	4,336	3,753	4,264	5,111	5,972	5,236	20.8
Screenings	2,622	1,357	853	967	698	689	-73.7
Special Groups	288	255	264	280	313	260	-9.7
Total	68,775	69,443	73,972	82,228	84,358	74,473	8.3

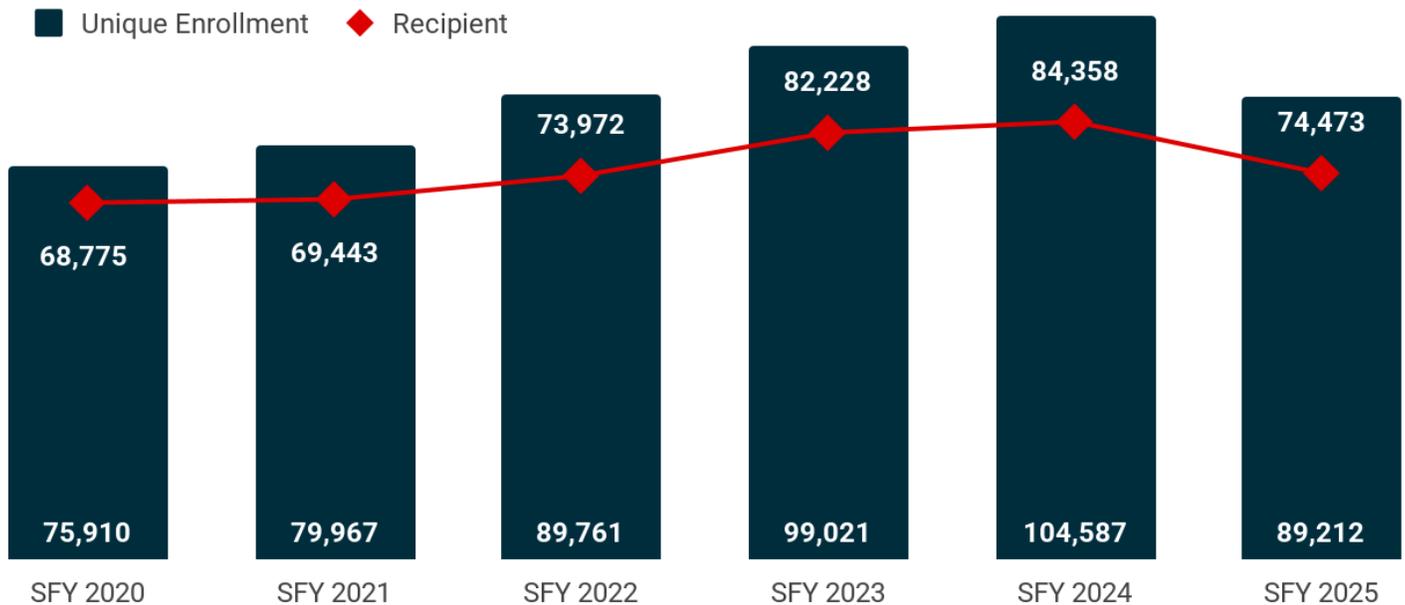


Figure 26. Historical Medicaid Enrollment vs. Medicaid Recipients by SFY

⁷ This column displays a distinct count of recipients for each eligibility category, as well as the total distinct count of recipients. Summing the recipients for each category will not match the total recipients as individuals may receive services under multiple eligibility categories throughout the SFY.

Table 10. Medicaid Recipient History by Service Type

Service Area	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Medical	65,573	65,263	70,239	78,728	80,528	70,563	7.6
Dental	24,732	29,329	30,566	32,955	31,498	29,817	20.6
Vision	12,680	15,761	15,808	16,933	15,795	14,651	15.5
Long-Term Care	8,493	7,942	7,739	7,975	8,206	8,020	-5.6
Other	860	776	625	948	748	875	1.7

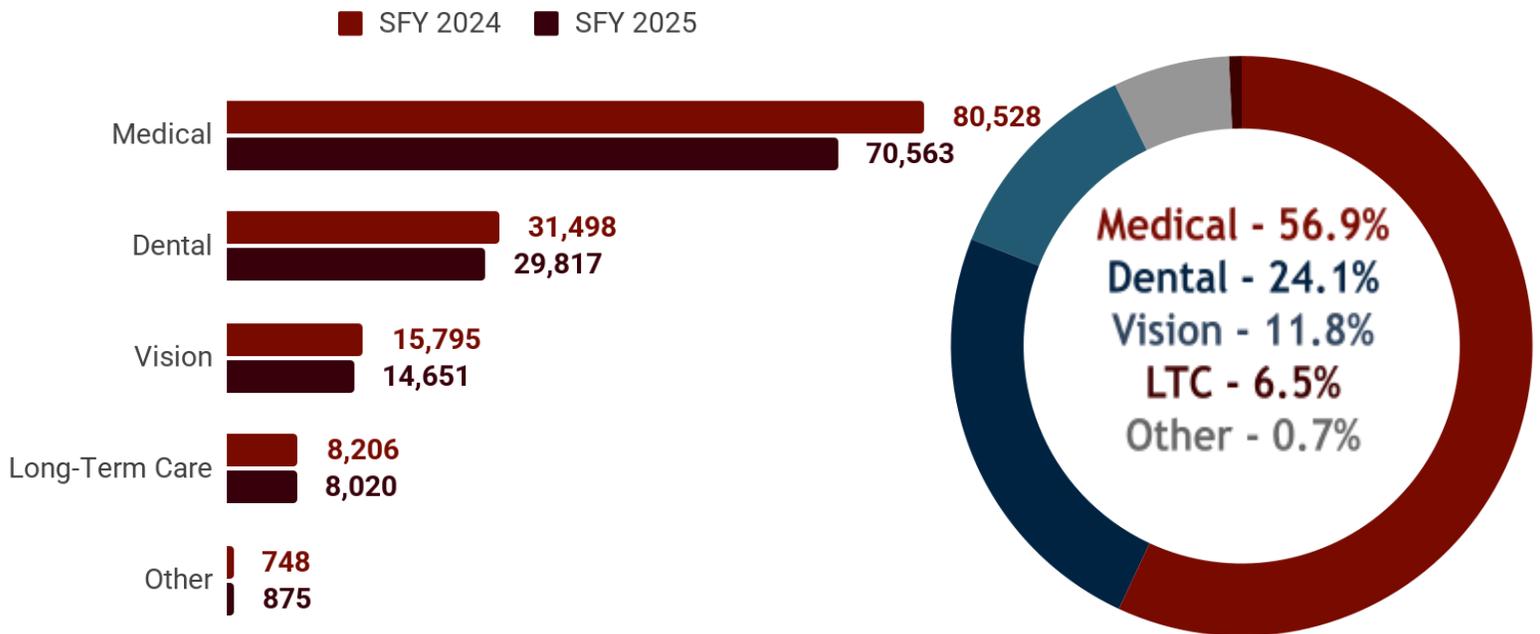


Figure 27. Comparison of Recipients by Service Type for SFY 2024 and SFY 2025

Figure 28. SFY 2025 Recipients by Service Type

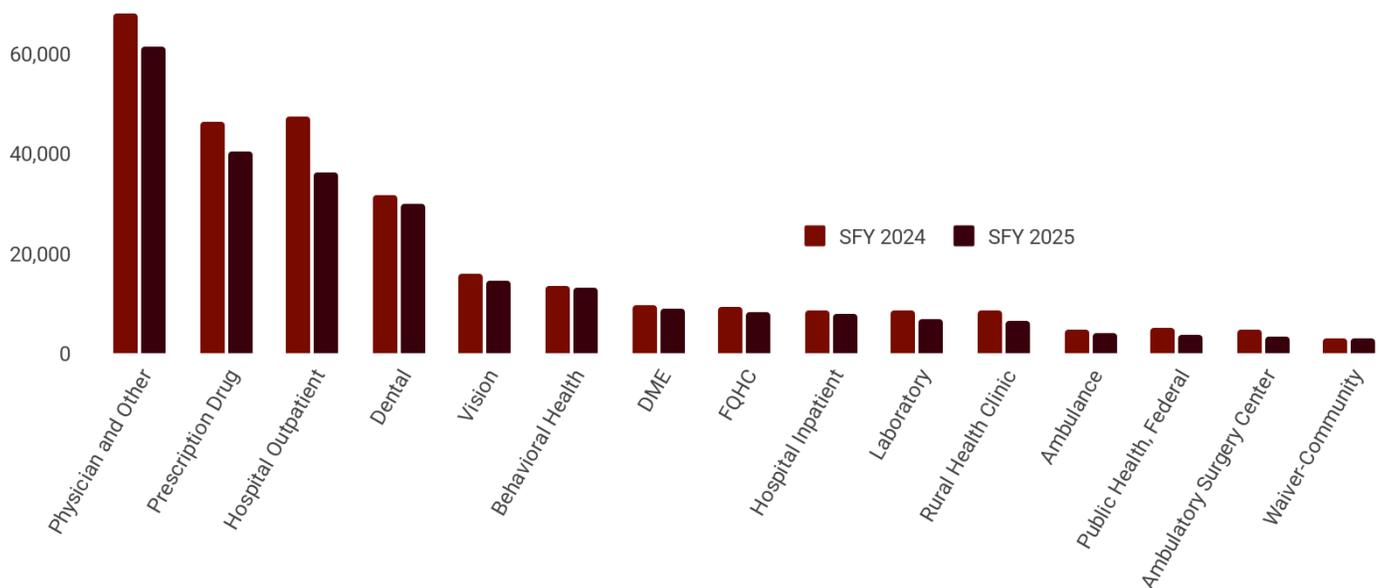


Figure 29. Comparison of Top Medicaid Services' Recipients for SFY 2024 and SFY 2025



SERVICES

Medicaid provides a wide range of covered medical, behavioral, and long-term care services. Some recipients receive full benefits while others receive partial or limited benefits. Medicaid covers mandatory services as required by the federal government and optional services authorized by the Wyoming Legislature. Rate information and reimbursement methodology and history are available in Appendix B.

Table 11. Covered Services

Service	Adult	Children
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Mandatory (EPSDT) ⁸
Audiologist and hearing aids	Optional	Mandatory (EPSDT)
Behavioral Health (including mental health and substance abuse related services) ⁹	Optional	Mandatory (EPSDT)
Care Management Entity wrap-around services	N/A	Optional
Case Management	Optional	Mandatory (EPSDT)
Certified pediatric and family nurse practitioner services	Mandatory	Mandatory
Children's Mental Health Waiver HCBS 1915c	N/A	Optional
Chiropractic	Not offered	Optional
Clinic services	Optional	Mandatory (EPSDT)
Community Choices Waiver HCBS 1915c	Optional	Optional
Comprehensive Waiver HCBS 1915c	Optional	Optional
Concurrent care for children receiving hospice	N/A	Mandatory
Dental services	Optional	Mandatory (EPSDT)
Dentures	Not offered	Mandatory (EPSDT)
Dietitian	Optional	Optional
Durable Medical Equipment, Prosthetics, Orthotics, & Supplies	Optional	Mandatory (EPSDT)
End Stage Renal Disease (ESRD) Clinic	Optional	Mandatory (EPSDT)
EPSDT Early Periodic Screening Detection and Treatment (EPSDT) for children	N/A	Mandatory
Eyeglasses	Optional	Mandatory (EPSDT)
Family Planning Services	Mandatory	Mandatory
Federally qualified health center (FQHC) services	Mandatory	Mandatory
Freestanding birth center services when licensed or otherwise recognized by the state ¹⁰	Mandatory	Mandatory
Home health services	Mandatory	Mandatory
Hospice	Optional	Mandatory (EPSDT)
Indian Health Services or Tribal 638 Facilities (Public Health, Federal)	Mandatory	Mandatory

⁸ EPSDT: Early Periodic Screening Detection & Treatment program.

⁹ Excludes Children's Mental Health Waiver & Psychiatric Residential Treatment Facility (PRTF). Information for these services is detailed below.

¹⁰ This service is mandatory by federal classification for in-state facilities. However, there are currently no licensed facilities in-state for this service.

Service	Adult	Children
Inpatient Hospital Services	Mandatory	Mandatory
Inpatient psychiatric hospital services for individuals under age 21	N/A	Mandatory (EPSDT)
Interpreter Services	Optional	Optional
Laboratory and X-ray services	Mandatory	Mandatory
Medication Assisted Treatment (MAT)	Mandatory	Mandatory
Nurse Midwife services	Mandatory	Mandatory
Nursing facility services	Mandatory	Mandatory
Occupational therapy	Optional	Mandatory (EPSDT)
Other diagnostic, screening, preventive, and rehabilitative services	Optional	Mandatory (EPSDT)
Other licensed practitioner services	Optional	Mandatory (EPSDT)
Outpatient Hospital Services	Mandatory	Mandatory
Personal care	Optional	Mandatory (EPSDT)
Pharmacist services (not pharmacy, but actual professional services provided by pharmacists)	Optional	Optional
Physical therapy	Optional	Mandatory (EPSDT)
Physician services	Mandatory	Mandatory
Podiatry	Optional	Optional
Pregnant By Choice Waiver (1115 Family Planning)	Optional	N/A ¹¹
Prescription drugs	Optional	Mandatory (EPSDT)
Primary care case management	Optional	Optional
Private duty nursing services	Not offered	Mandatory (EPSDT)
Prosthetics	Optional	Mandatory (EPSDT)
Psychiatric Residential Treatment Facility (PRTF) under age 21	N/A	Optional
Public Health Nursing (Public Health or Welfare)	Optional	Optional
Respiratory care for ventilator-dependent individuals	Optional	Mandatory (EPSDT)
Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials	Mandatory	Mandatory
Rural Health Clinic (RHC) Services	Mandatory	Mandatory
Self-directed personal assistance services	Optional	Optional
Services for individuals age 65 or older in an Institution for Mental Disease (IMD)	Optional	N/A
Services for individuals with Autism Spectrum Disorder	Not offered	Mandatory (EPSDT)
Services in an intermediate care facility for Individuals with intellectual disability (ICF-ID)	Optional	Optional
Speech, hearing and language disorder services	Optional	Mandatory (EPSDT)
Support Waiver HCBS 1915c	Optional	Optional
Targeted Case Management	Optional	Optional
TB-related services	Optional	Mandatory (EPSDT)
Tobacco cessation counseling for pregnant women	Mandatory	Mandatory
Transplants (kidney, liver and bone marrow)	Optional	Mandatory (EPSDT)
Transportation to medical care	Mandatory	Mandatory
Vision exams and treatment	Optional	Mandatory (EPSDT)

¹¹ The children population is not included for this service as Wyoming children who meet the eligibility criteria for this program are eligible under Medicaid and M-CHIP without the waiver.

Table 12. Medicaid Service Utilization Summary

Member Core ID	2025 Expenditures	% Change from SFY 2024	2025 Recipients	% Change from SFY 2024	2025 Expenditures per Recipients	% Change from SFY 2024
Ambulance	\$4,766,239	-5.9	3,986	-15.6	\$1,196	11.6
Ambulatory Surgery Center	\$5,851,382	-10.6	4,797	-25.9	\$1,646	20.6
Behavioral Health	\$19,414,501	4.5	13,080	-4.1	\$1,484	8.9
Care Management Entity	\$4,474,014	42.7	650	-12.3	\$7,849	62.7
Clinic/Center	\$1,112,391	7.2	1,307	-1.1	\$851	8.3
Dental	\$16,127,481	0.5	31,498	-5.3	\$541	6.2
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	\$11,817,349	-2.1	8,847	-7.7	\$1,336	6.1
End-Stage Renal Disease	\$1,930,967	20.9	160	-25.6	\$16,227	62.5
Federally Qualified Health Center	\$9,259,051	-13.1	8,370	-8.7	\$1,106	-4.8
Home Health	\$519,329	-8.0	323	-2.8	\$1,654	-5.4
Hospice	\$2,797,333	30.0	268	-1.1	\$10,438	31.5
Hospital Total	\$102,639,494	-7.4	56,416	-20.8	\$2,297	16.9
Hospital Inpatient	\$71,992,509	-3.5	8,098	-4.9	\$8,890	1.5
Hospital Outpatient	\$30,645,981	-15.5	47,515	-23.1	\$839	9.9
Hospital-Other	\$1,004	-95.2	38	-90.1	\$26	-51.2
Intermediate Care Facility for Individuals with Intellectual Disabilities	\$14,256,180	-12.9	36	-2.8	\$407,319	-10.4
Laboratory	\$2,315,934	17.5	7,033	-19.5	\$329	46.0
Nursing Facility	\$89,669,389	-5.0	2,262	-15.2	\$46,752	12.1
Other	\$257,313	-11.2	871	19.5	\$295	-25.7
Physician and Other Practitioner	\$53,360,072	-10.3	67,855	-9.7	\$871	-0.7
Prescription Drug	\$97,550,954	-0.1	40,372	-12.7	\$2,416	14.5
Psychiatric Residential Treatment Facility	\$12,848,262	11.5	204	-1.0	\$63,605	12.6
Public Health or Welfare	\$271,422	58.7	2,197	-22.8	\$124	105.6
Public Health, Federal	\$24,636,454	-17.5	5,205	-25.9	\$6,384	11.3
Rural Health Clinic	\$3,343,108	-25.3	6,699	-22.6	\$499	-3.5
Targeted Case Management	-0.1	-0.1	871	0.2	\$133	-27.3
Vision	\$3,612,583	-2.3	15,795	-7.2	\$247	5.4
Waiver Total	\$184,231,921	4.4	6,041	2.0	\$30,497	2.4
Waiver-Community Choices	\$39,030,678	2.2	2,972	-0.4	\$13,190	2.6
Waiver-Comprehensive	\$126,901,439	1.8	1,781	-1.3	\$71,253	3.2
Waiver-Supports	\$18,299,803	34.0	1,148	13.3	\$14,066	18.3
Total	\$667,179,184	-2.6	74,473	-11.7	\$8,959	10.4



AMBULANCE

Emergency ground and air transportation and limited non-emergent ground transportation.

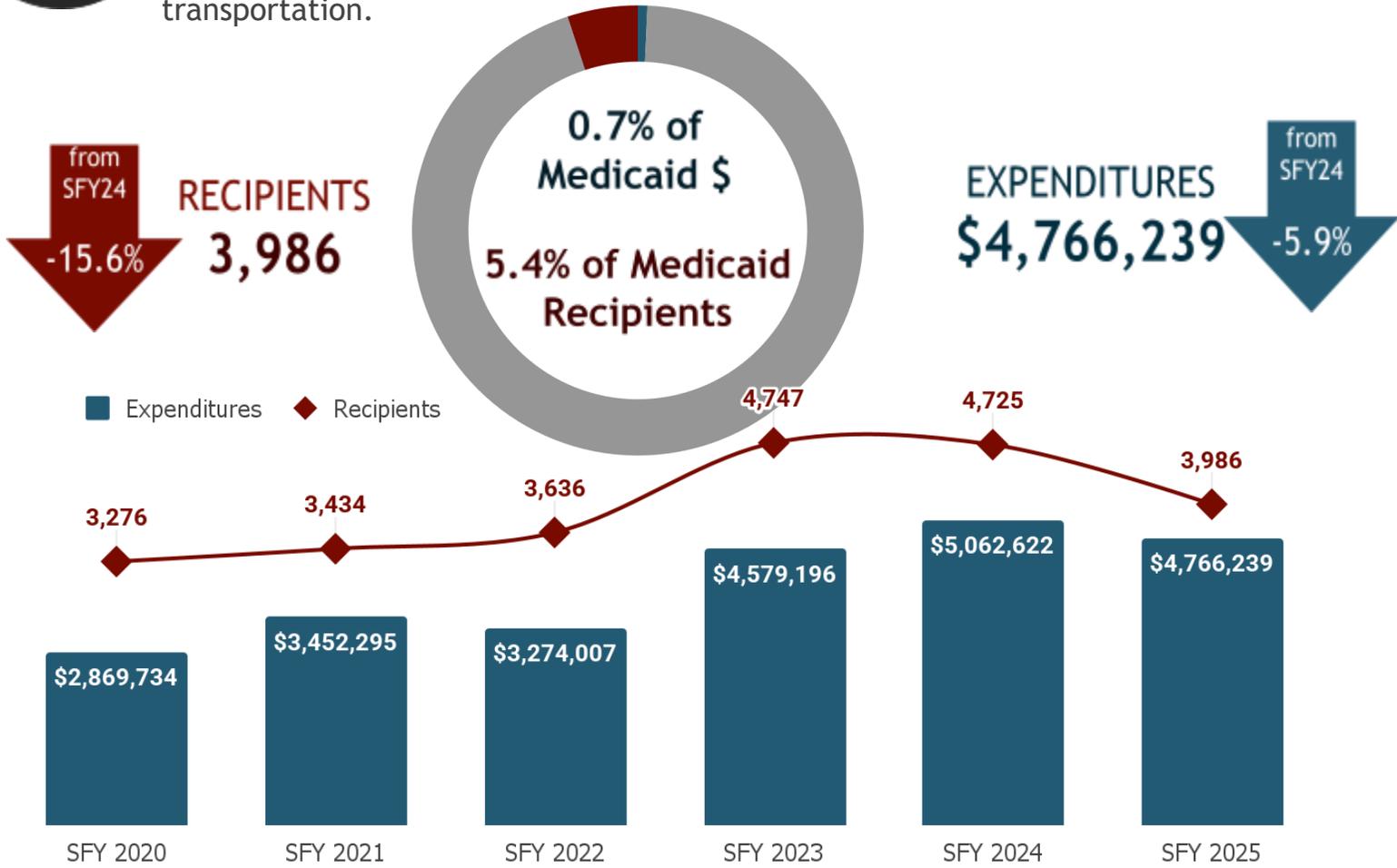


Table 13. Ambulance Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$2,869,734	\$3,452,295	\$3,274,007	\$4,579,196	\$5,062,622	\$4,766,239	66.1
Air Ambulance	\$1,823,177	\$2,344,106	\$2,269,495	\$3,059,405	\$3,400,501	\$3,402,112	86.6
Ground Ambulance	\$1,046,556	\$1,108,189	\$1,004,512	\$1,519,791	\$1,662,121	\$1,364,127	30.3
Recipients¹²	3,276	3,434	3,636	4,747	4,725	3,986	21.7
Air Ambulance	460	586	576	732	759	719	56.3
Ground Ambulance	3,092	3,190	3,388	4,459	4,470	3,720	20.3
Expenditures per Recipient	\$876	\$1,005	\$900	\$965	\$1,071	\$1,196	36.5
Air Ambulance	\$3,963	\$4,000	\$3,940	\$4,180	\$4,480	\$4,732	19.4
Ground Ambulance	\$338	\$347	\$296	\$341	\$372	\$367	8.3

¹² The recipient rows display a distinct count of recipients for each ambulance category, as well as the total distinct count of recipients. Summing the recipients for each category will not match the total recipients as individuals may receive multiple types of ambulance services throughout the SFY.



AMBULATORY SURGICAL CENTER

Surgical procedures that do not require overnight inpatient hospital care. It encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. Ambulatory Surgical Center (ASC) services may also be provided in an outpatient hospital setting.

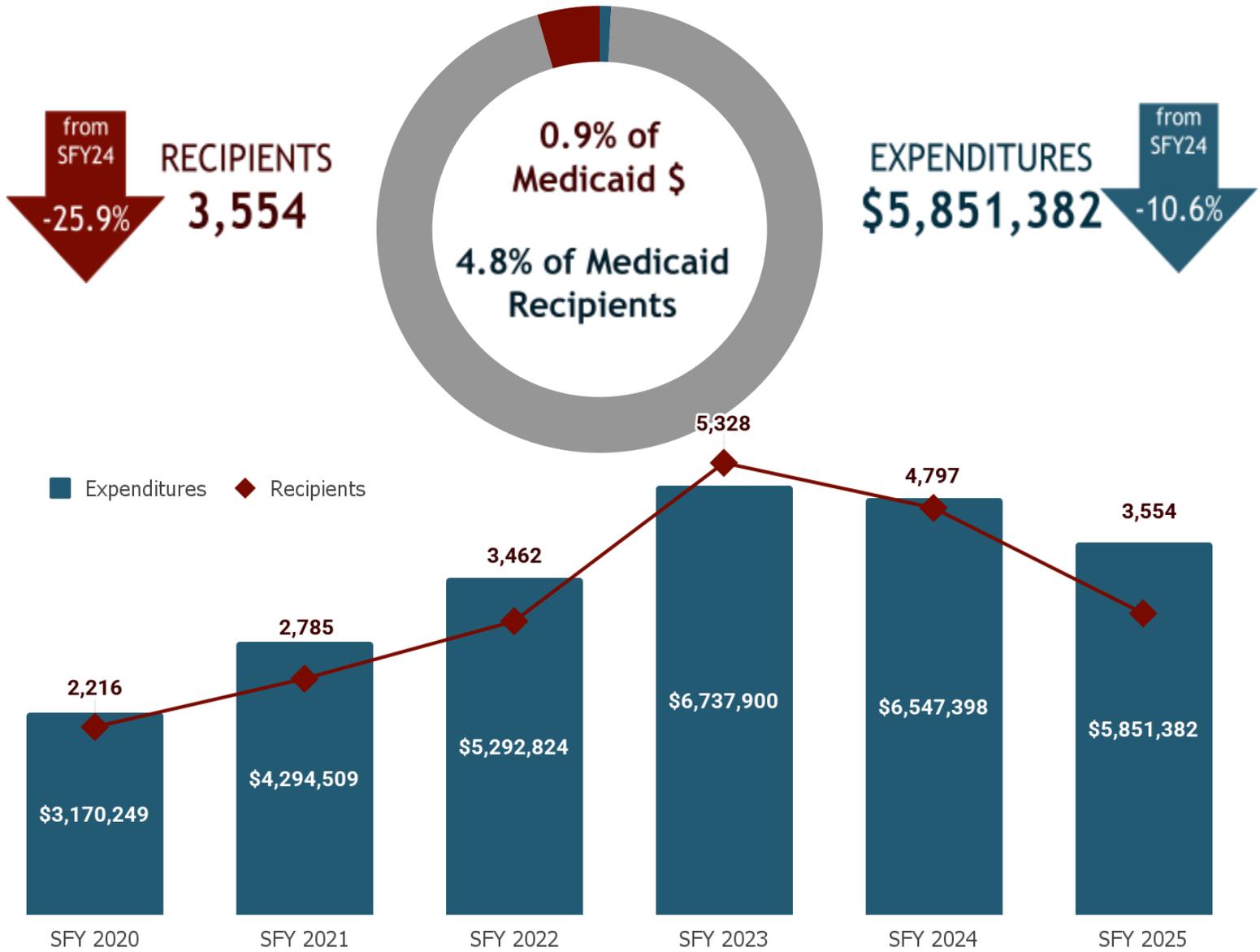


Table 14. Ambulatory Surgical Center Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$3,170,249	\$4,294,509	\$5,292,824	\$6,737,900	\$6,547,398	\$5,851,382	84.6
Recipients	2,216	2,785	3,462	5,328	4,797	3,554	60.4
Expenditures Per Recipient	\$1,431	\$1,542	\$1,529	\$1,265	\$1,365	\$1,646	15.1



BEHAVIORAL HEALTH

Outpatient and community-based behavioral health services for Wyoming Medicaid clients who are experiencing mental health and/or substance use symptoms.

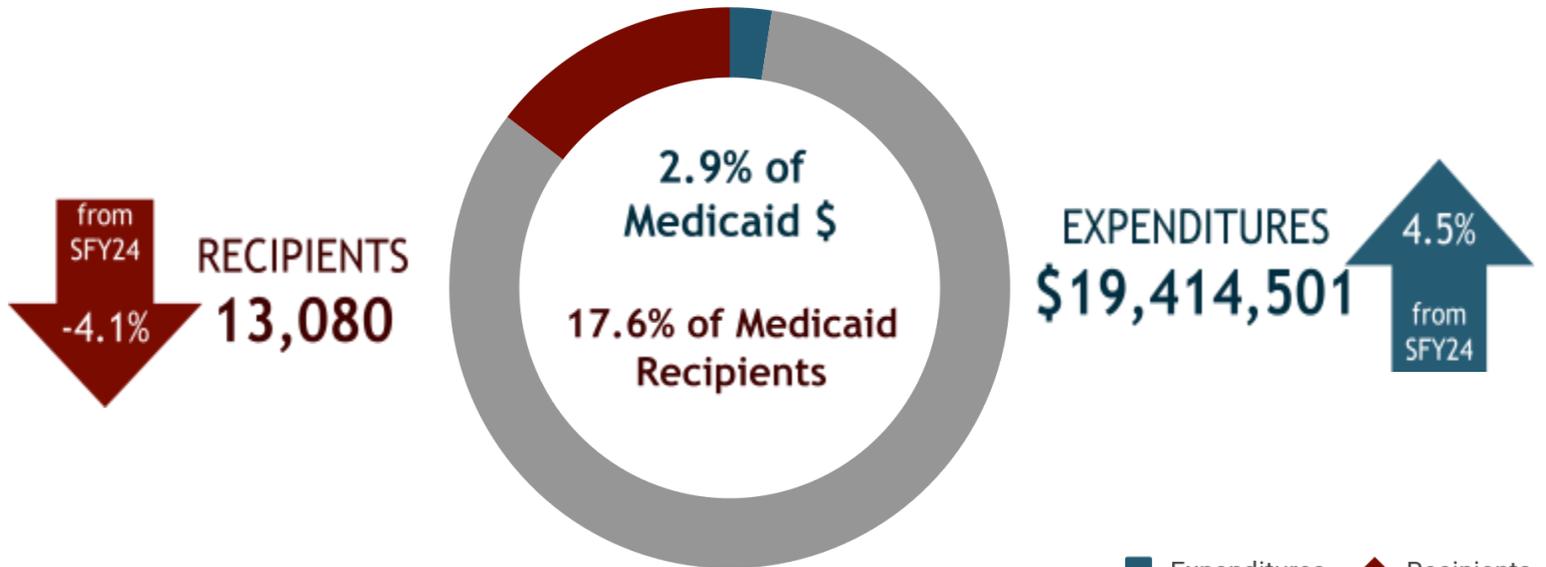


Table 15. Behavioral Health Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$22,191,112	\$20,851,243	\$18,166,144	\$18,779,858	\$18,578,363	\$19,414,501	-12.5
Recipients	11,789	11,816	12,466	13,839	13,633	13,080	11.0
Expenditures Per Recipient	\$1,882	\$1,765	\$1,457	\$1,357	\$1,363	\$1,484	-21.1

Figure 30. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Alzheimer’s and Other Types of Dementia)

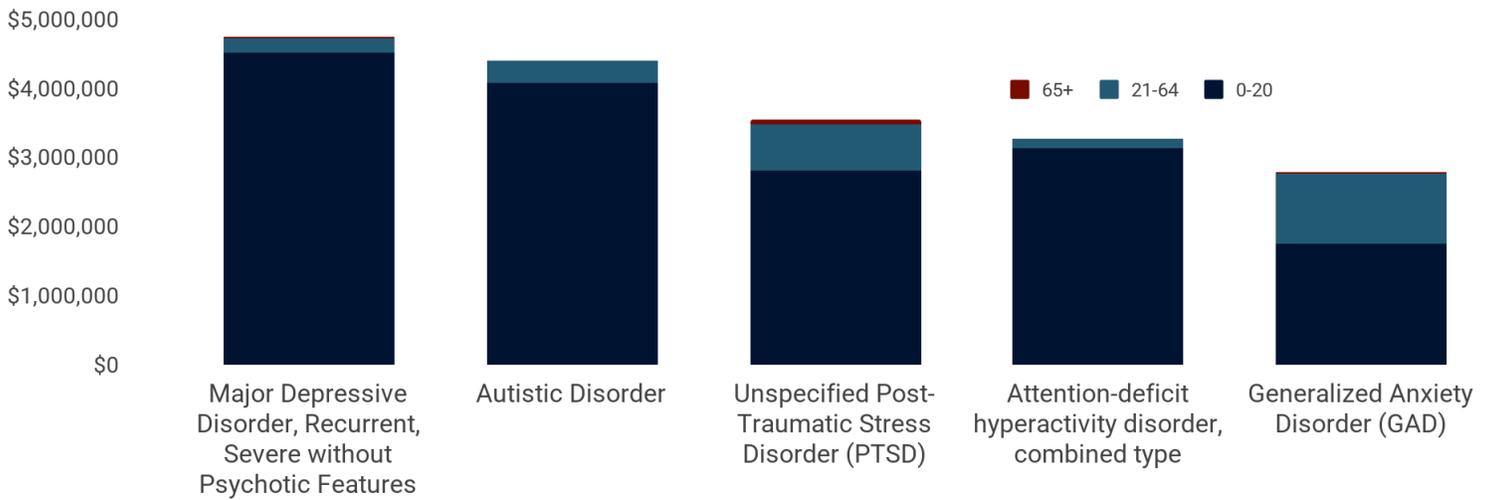


Table 16. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types¹³ (excluding Alzheimer’s and Other Types of Dementia)

Diagnosis Description	Age 0-20	Age 21-64	Age 65+	Total
Major Depressive Disorder, Recurrent, Severe without Psychotic Features	\$4,527,049	\$214,646	\$5,890	\$4,747,585
Autistic Disorder	\$4,080,316	\$323,603	\$1,720	\$4,405,639
Unspecified Post-Traumatic Stress Disorder (PTSD)	\$2,822,563	\$669,726	\$76,687	\$3,568,976
Attention-deficit hyperactivity disorder, combined type	\$3,136,335	\$143,672	\$38	\$3,280,044
Generalized Anxiety Disorder (GAD)	\$1,753,667	\$1,024,263	\$27,337	\$2,805,267
Total	\$16,319,929	\$2,375,910	\$111,673	\$18,807,512

On January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) required Medicaid programs to provide medically necessary diagnostic and treatment services to beneficiaries with Autism Spectrum Disorder (ASD) under the age of 21 years. Applied Behavior Analysis (ABA) treatment was implemented.

Table 17. Applied Behavioral Analysis Service Utilization History

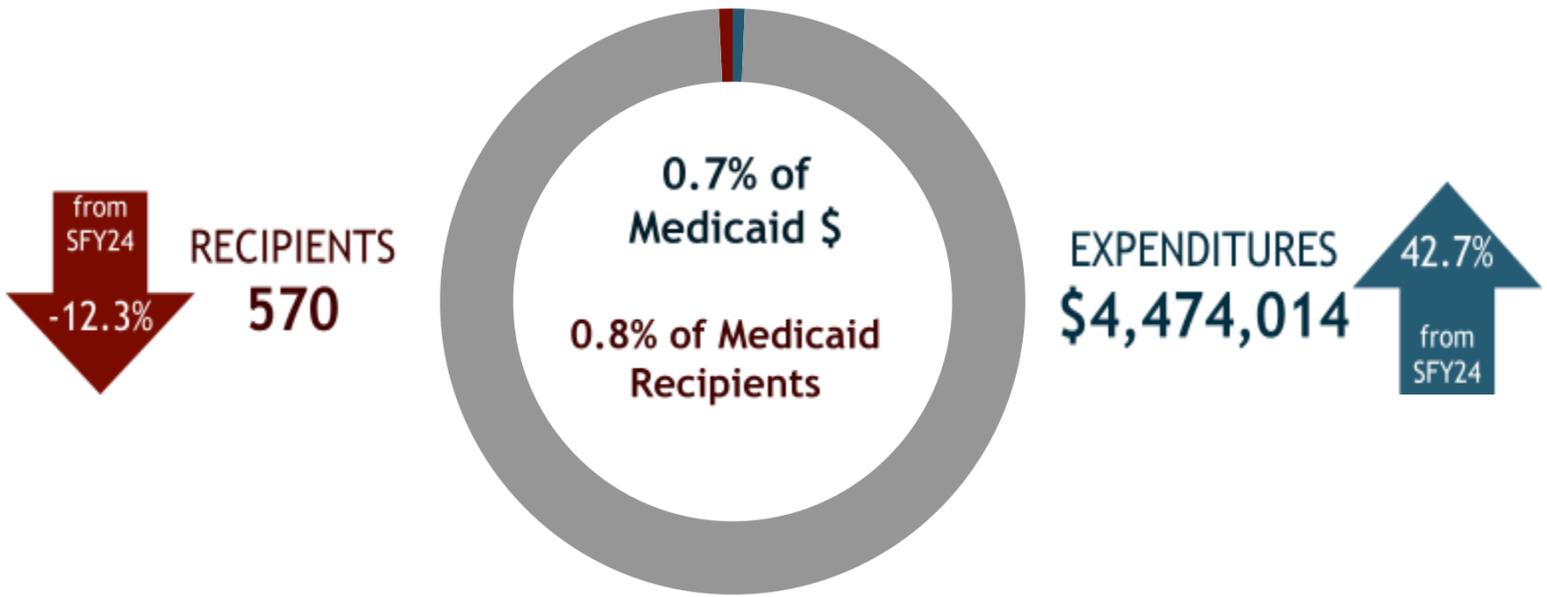
Applied Behavioral Analysis	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$847,464	\$1,677,538	\$1,433,378	\$600,719	\$1,019,561	\$2,259,627	166.6
Recipients	77	72	58	53	90	129	67.5
Expenditures per Recipient	\$11,006	\$23,299	\$24,713	\$11,334	\$11,328	\$17,516	59.2
Providers	7	5	6	8	8	10	42.9

¹³ See Appendix B for additional information regarding the types of providers who provide Behavioral Health services.



CARE MANAGEMENT ENTITY

Provides intensive care coordination to children and youth with complex behavioral health conditions and their families, using a High Fidelity Wrap-around model to support their success in their homes, schools, and communities.



■ Expenditures ◆ Recipients

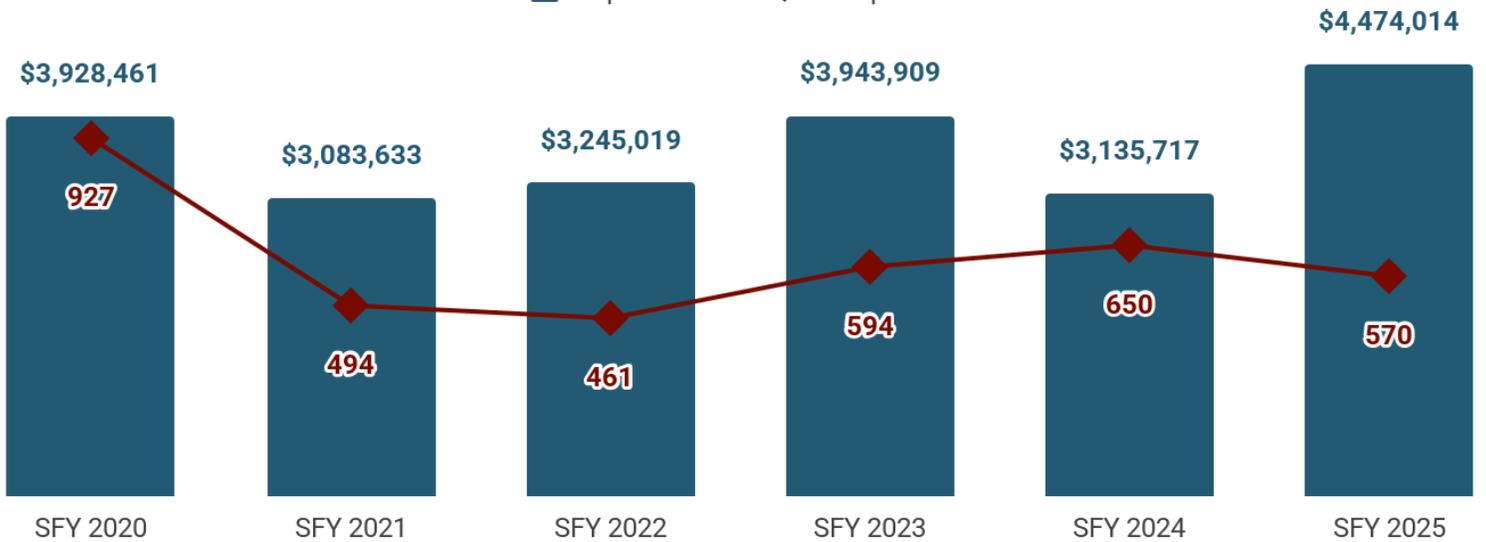


Table 18. Care Management Entity Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$3,928,461	\$3,083,633	\$3,245,019	\$3,943,909	\$3,135,717	\$4,474,014	13.9
Recipients	927	494	461	594	650	570	-38.5
Expenditures Per Recipient	\$4,238	\$6,242	\$7,039	\$6,640	\$4,824	\$7,849	85.2



CLINIC/CENTER (DEVELOPMENTAL CENTERS)

Services for members with disabilities at IDEA Part B and C Developmental Centers, which are often referred to as “developmental preschools”. This area pays for medically necessary services including diagnostic evaluations and assessments, physical, occupational, and speech therapies, and mental health services for clients age 5 and younger.

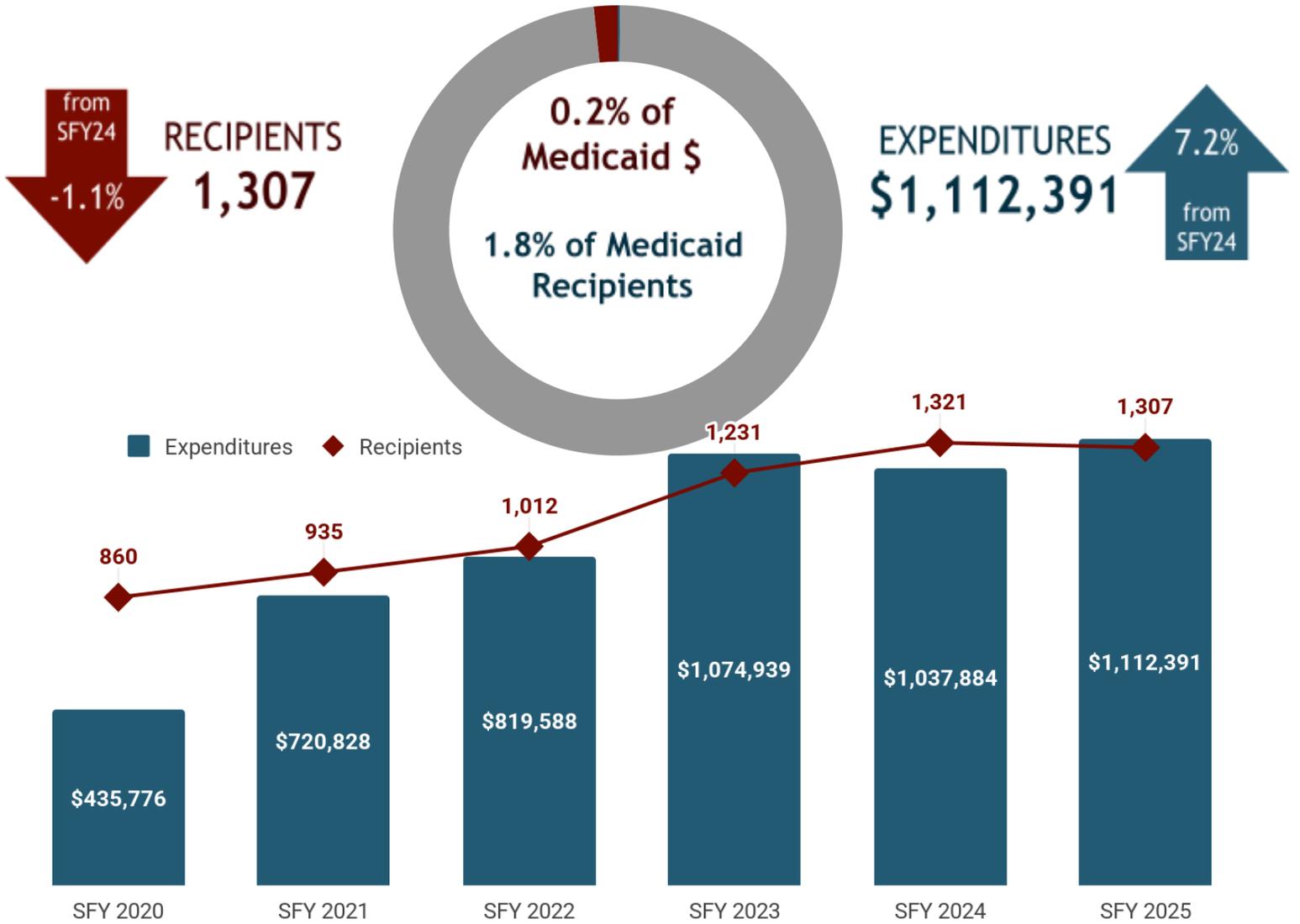


Table 19. Clinic/Center Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$435,776	\$720,828	\$819,588	\$1,074,939	\$1,037,884	\$1,112,391	155.3
Recipients	860	935	1,012	1,231	1,321	1,307	52.0
Expenditures Per Recipient	\$507	\$771	\$810	\$873	\$786	\$851	68.0



DENTAL

Dental services are covered based on enrolled members' age, with the goal of ensuring access to dental care so recipients may avoid emergency dental situations by receiving preventive and routine dental services for overall oral health.

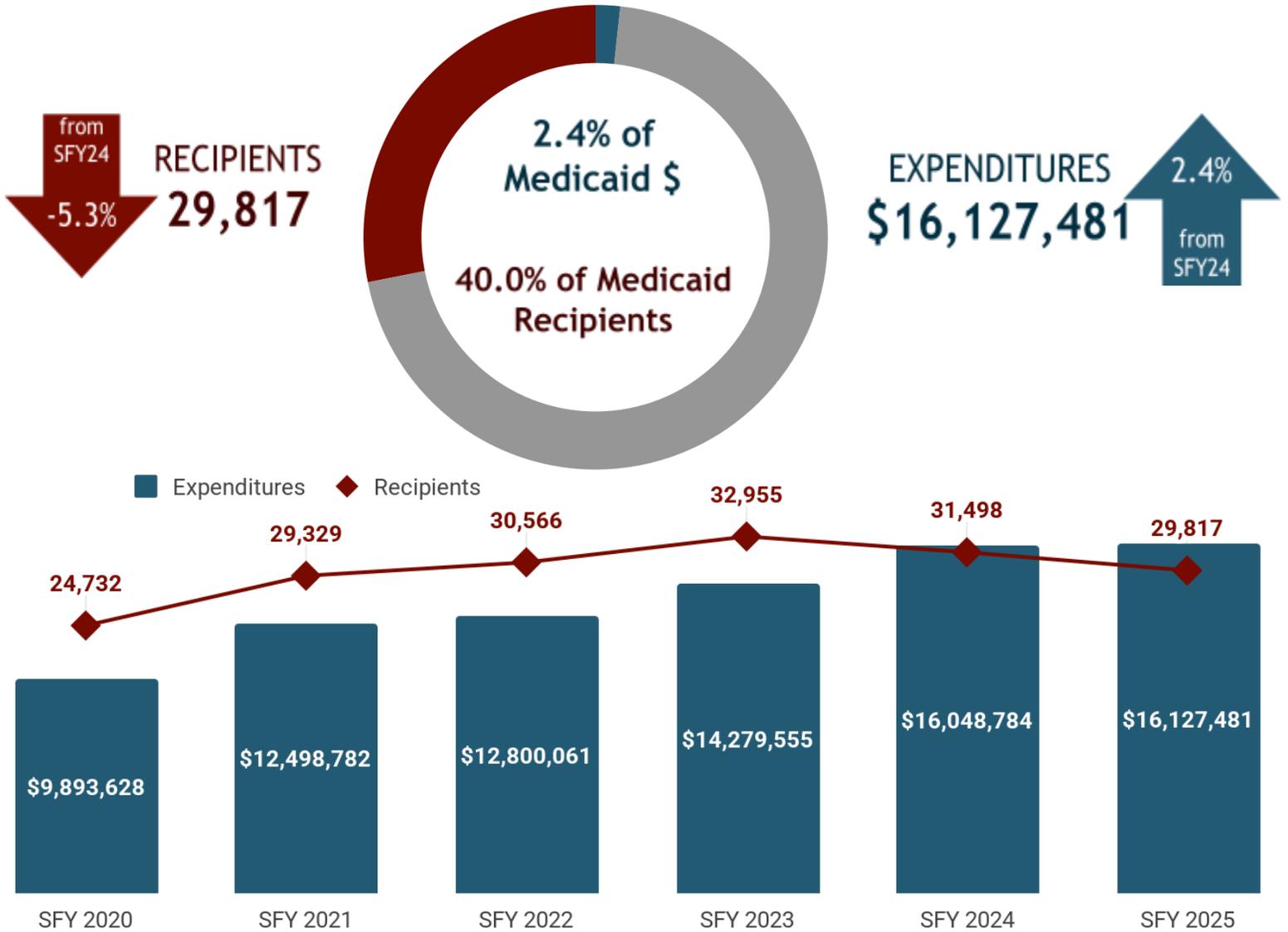


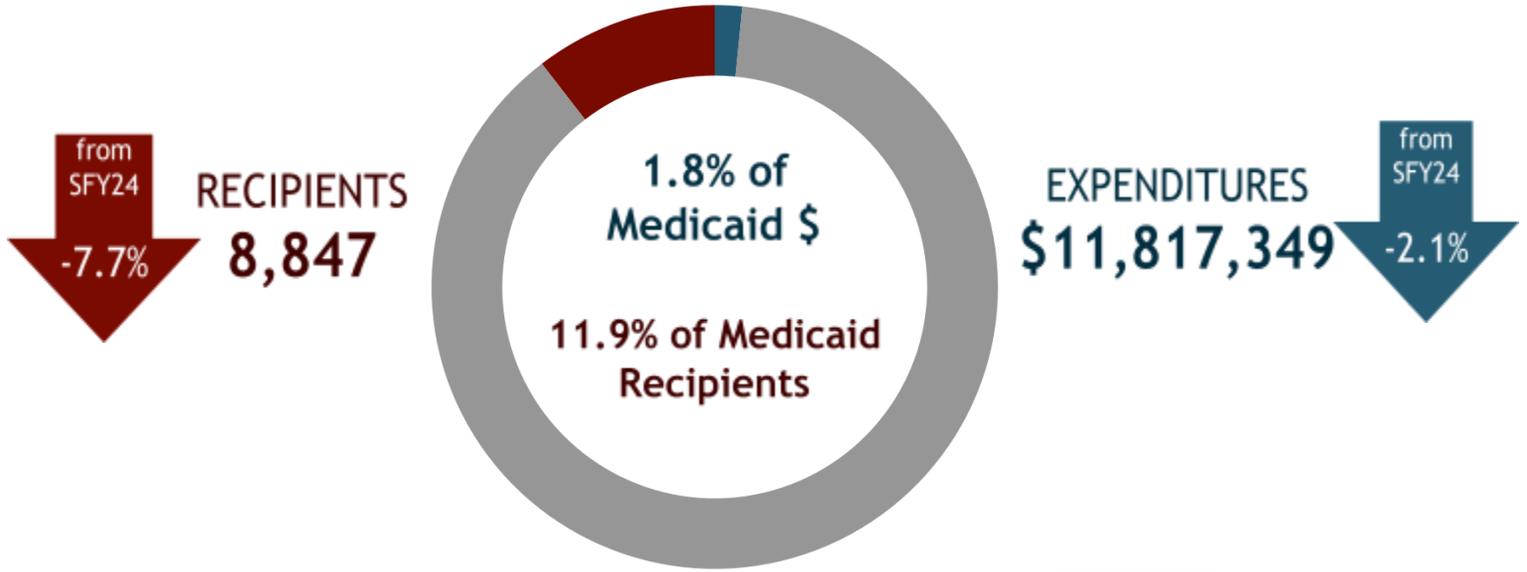
Table 20. Dental Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$9,893,628	\$12,498,782	\$12,800,061	\$14,279,555	\$16,048,784	\$16,127,481	63.0
Recipients	24,732	29,329	30,566	32,955	31,498	29,817	20.6
Expenditures Per Recipient	\$400	\$426	\$419	\$433	\$510	\$541	35.2



DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, & SUPPLIES (DME)

Services are covered when ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to a functional level for an injury and chronic health issue.



from SFY24
-7.7%

RECIPIENTS
8,847

EXPENDITURES
\$11,817,349
from SFY24
-2.1%



Table 21. DME Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$9,490,752	\$9,897,029	\$10,002,918	\$11,764,681	\$12,074,484	\$11,817,349	24.5
Recipients	7,712	8,286	9,021	9,749	9,590	8,847	14.7
Expenditures Per Recipient	\$1,231	\$1,194	\$1,109	\$1,207	\$1,259	\$1,336	8.5



END-STAGE RENAL DISEASE

All medically necessary services related to renal disease care, including inpatient renal dialysis and outpatient services related to end-stage renal disease (ESRD) treatment, as well as treatment if Medicare denies coverage for an enrolled member on a home dialysis program. A hospital or free-standing facility must be a certified ESRD facility. Personal care attendants are not covered by this program. The majority of ESRD recipients are dual individuals, those enrolled in both Medicare and Medicaid. Medicare is the primary payer for End-Stage Renal Disease (ESRD) services for dual individuals, and therefore most Medicaid ESRD expenditures are for Medicaid-only individuals.

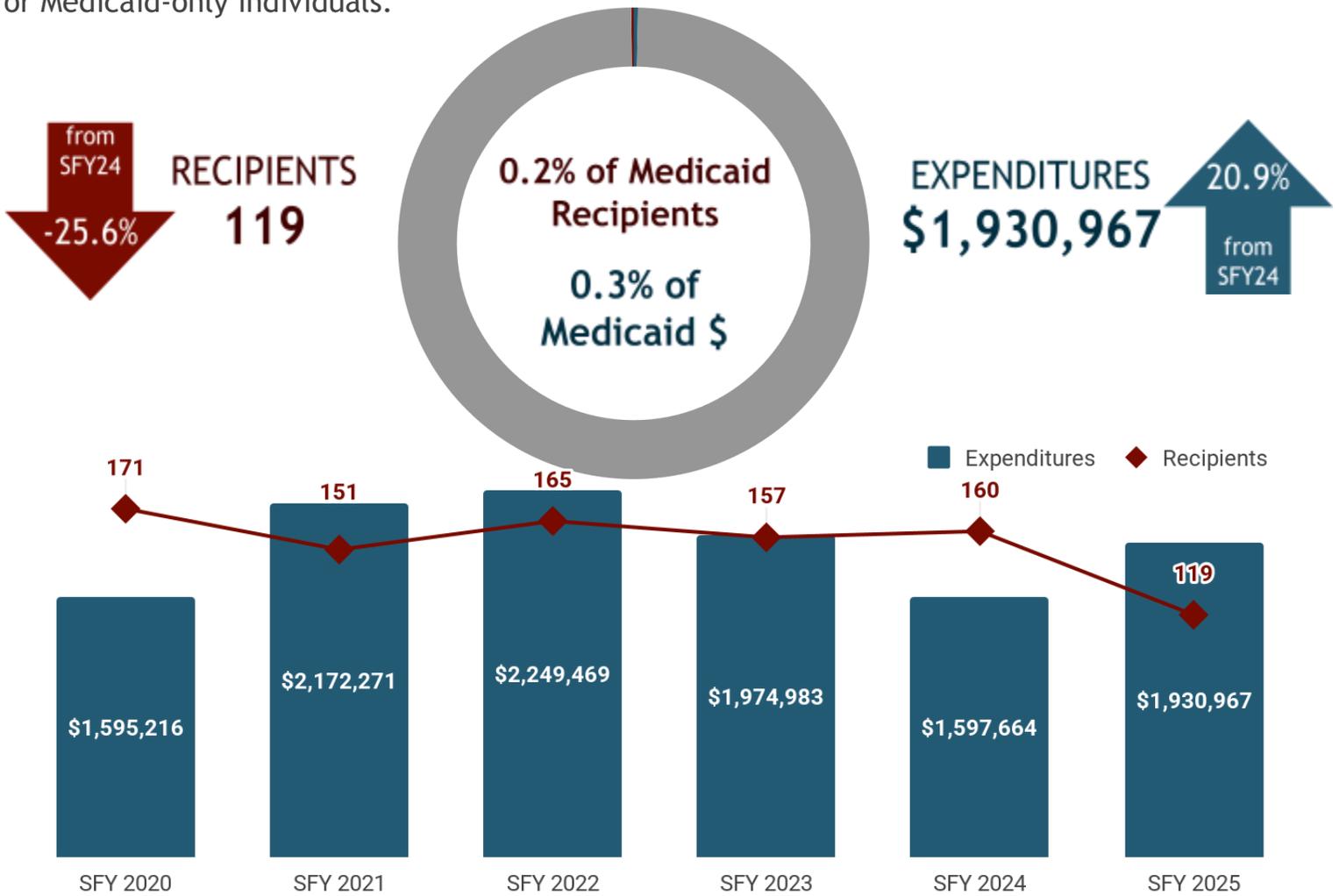


Table 22. End-Stage Renal Service Utilization History.

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$1,595,216	\$2,172,271	\$2,249,469	\$1,974,983	\$1,597,664	\$1,930,967	21.0
Recipients	171	151	165	157	160	119	-30.4
Expenditures Per Recipient	\$9,329	\$14,386	\$13,633	\$12,580	\$9,985	\$16,227	73.9



FEDERALLY QUALIFIED HEALTH CENTER

Provides preventive primary health services when medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, dentist, orthodontist, licensed clinical psychologist, or licensed clinical social worker. The facility is designated as an FQHC by Medicare if it is located in an area designated as a “shortage area”, a geographic area designated by HHS as having either a shortage of personal health services or of primary medical care professionals.

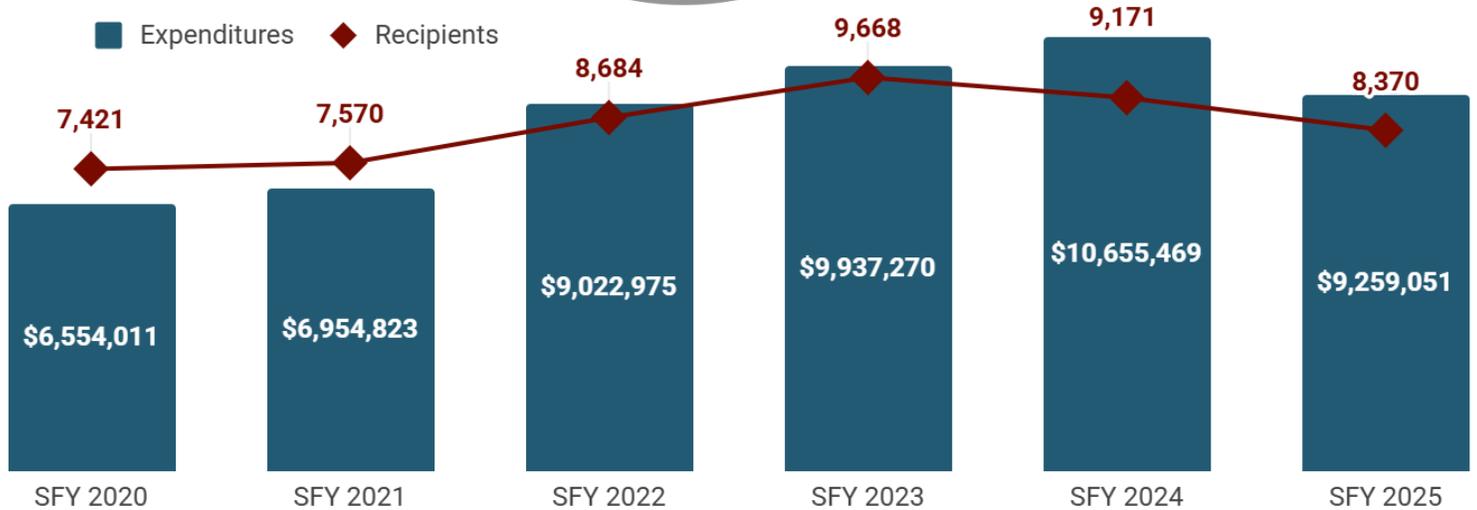
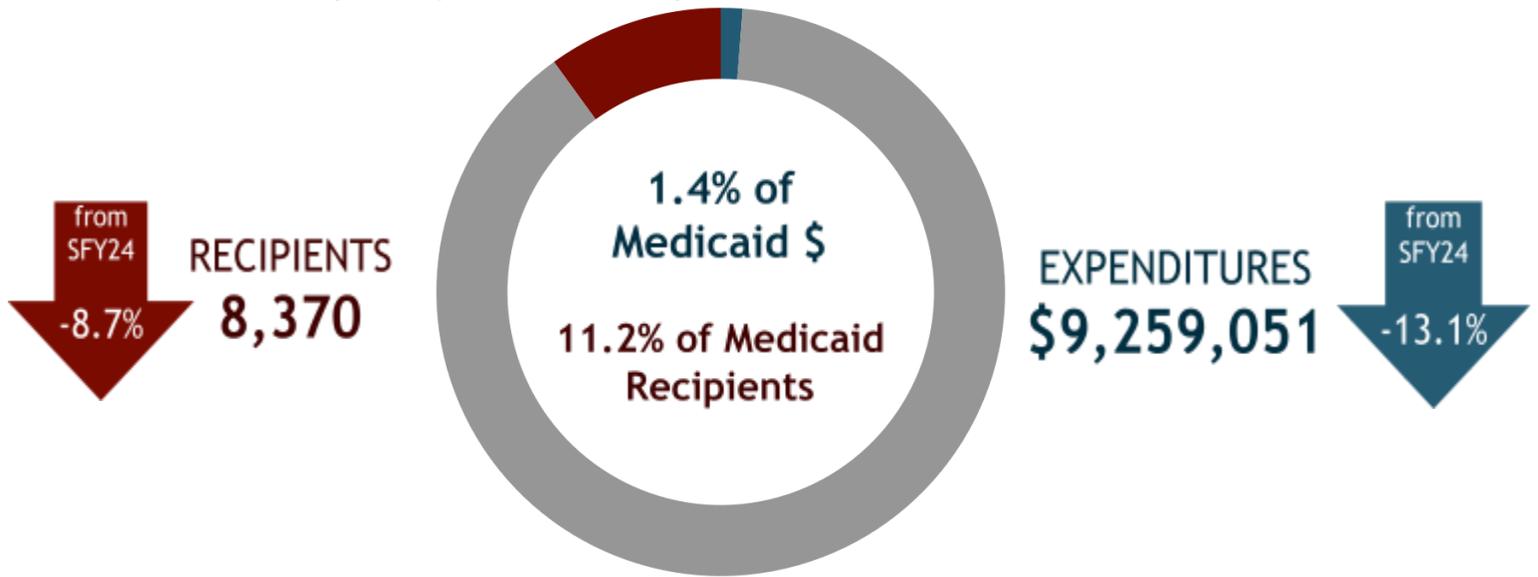


Table 23. Federally Qualified Health Center Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$6,554,011	\$6,954,823	\$9,022,975	\$9,937,270	\$10,655,469	\$9,259,051	41.3
Recipients	7,421	7,570	8,684	9,668	9,171	8,370	12.8
Expenditures Per Recipient	\$883	\$919	\$1,039	\$1,028	\$1,162	\$1,106	25.3



HOME HEALTH

Services are intended to be a temporary transitional program to assist members with care required after an acute health incident or an institutional stay. The services are intermittent and assist with medical support and education to the Member and any caregiver regarding the member’s new medical needs. Services must be medically necessary, ordered by a physician, and documented in a signed/dated treatment plan to be reviewed and revised as medically necessary by the attending physician at least every 60 days.

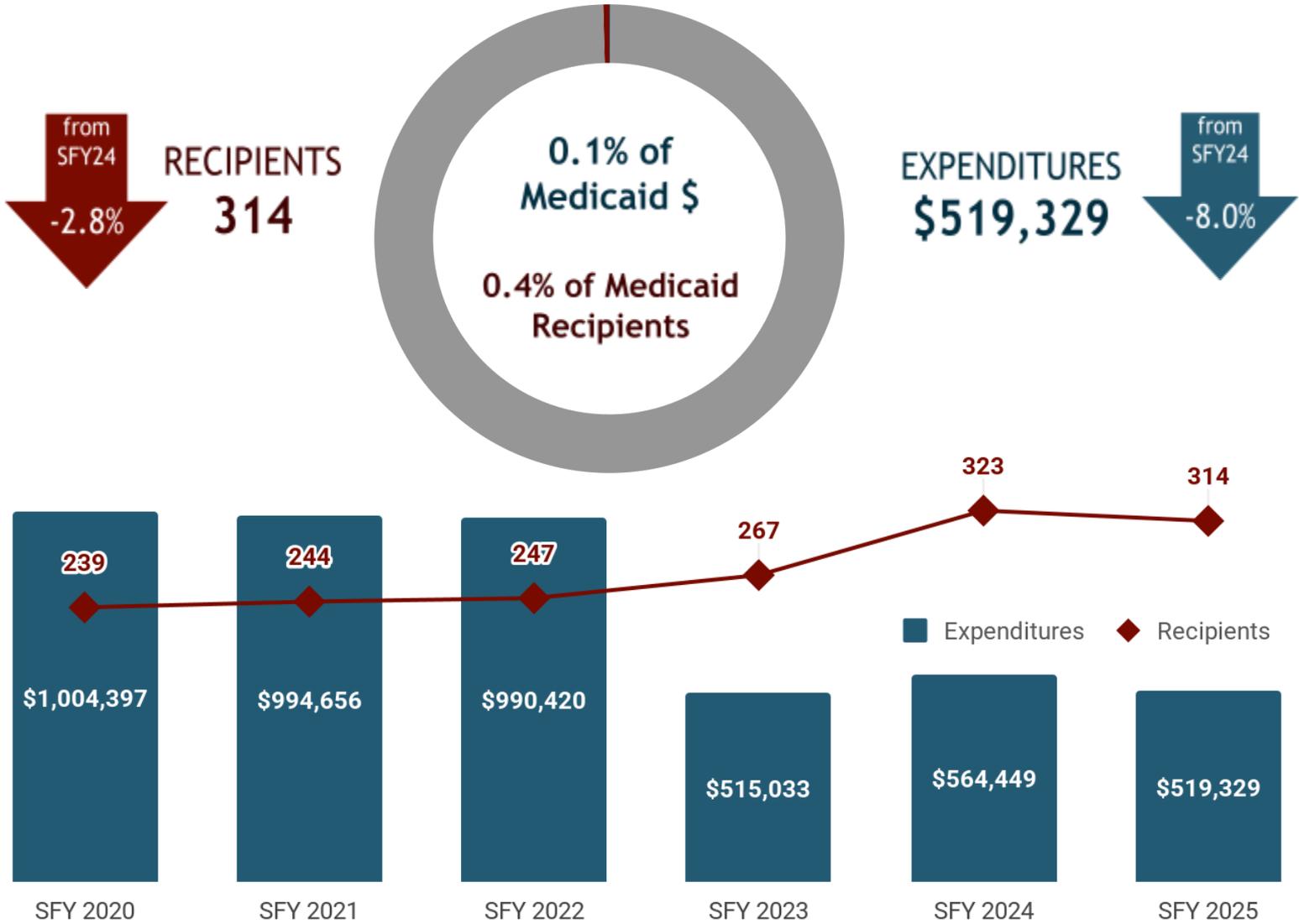


Table 24. Home Health Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$1,004,397	\$994,656	\$990,420	\$515,033	\$564,449	\$519,329	-48.3
Recipients	239	244	247	267	323	314	31.4
Expenditures Per Recipient	\$4,202	\$4,076	\$4,010	\$1,929	\$1,748	\$1,654	-60.6



HOSPICE

Hospice care is covered if the individual elects palliative care and a physician certifies that the individual is terminally ill. Covered services include routine and continuous home care, inpatient respite care, and general inpatient care. Inpatient services are provided during critical periods for individuals who need a high level of care. Hospice care is available to eligible Members of any age and may be provided in a home setting, nursing facility and freestanding hospice facility.

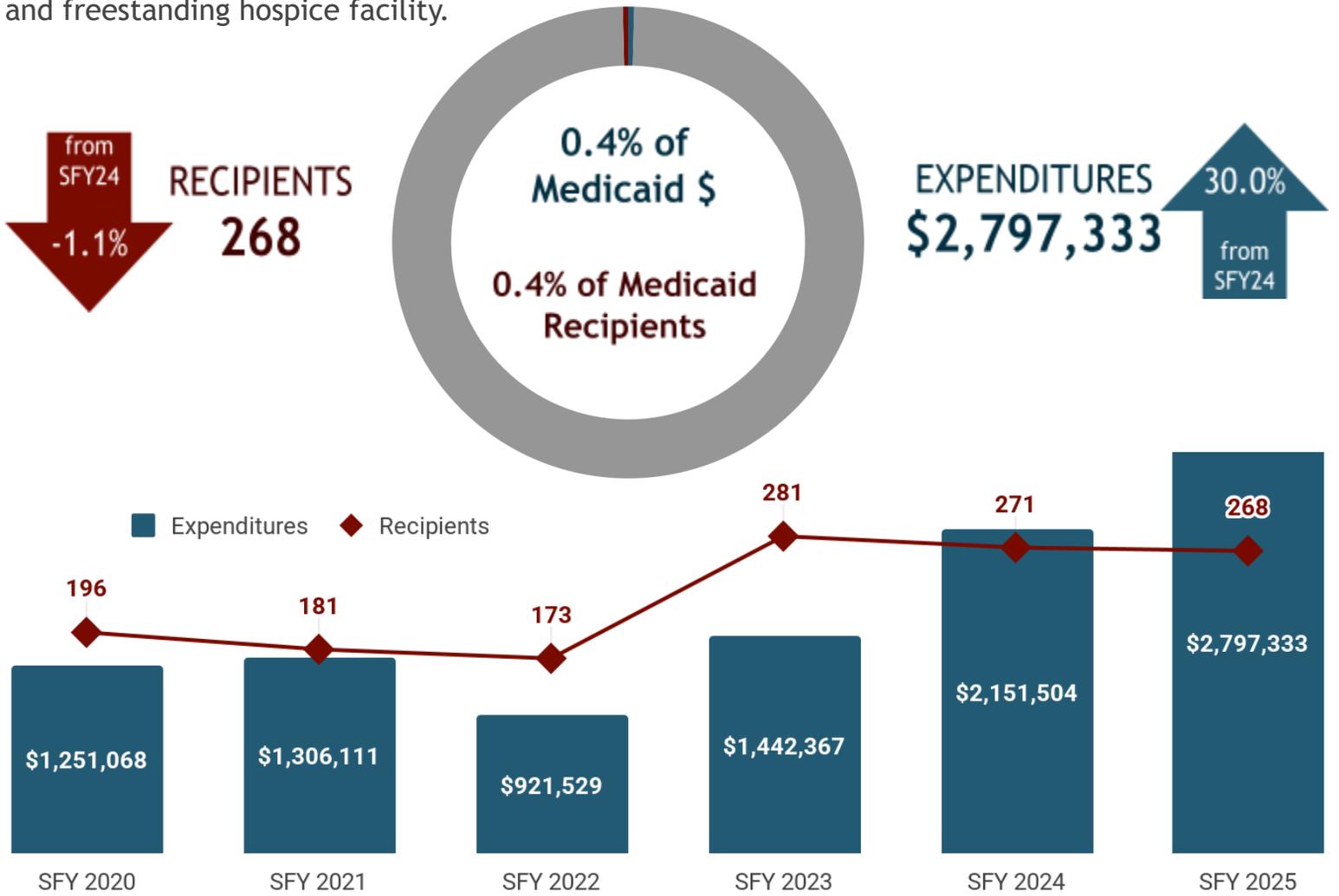


Table 25. Hospice Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$1,251,068	\$1,306,111	\$921,529	\$1,442,367	\$2,151,504	\$2,797,333	123.6
Recipients	196	181	173	281	271	268	36.7
Expenditures Per Recipient	\$6,383	\$7,216	\$5,327	\$5,133	\$7,939	\$10,438	63.5



HOSPITAL - INPATIENT

Medicaid covers inpatient hospital services with the exception of alcohol and chemical rehabilitation services, cosmetic surgery, and experimental services. Surgical procedures must be medically necessary, and may not be covered if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the individual.

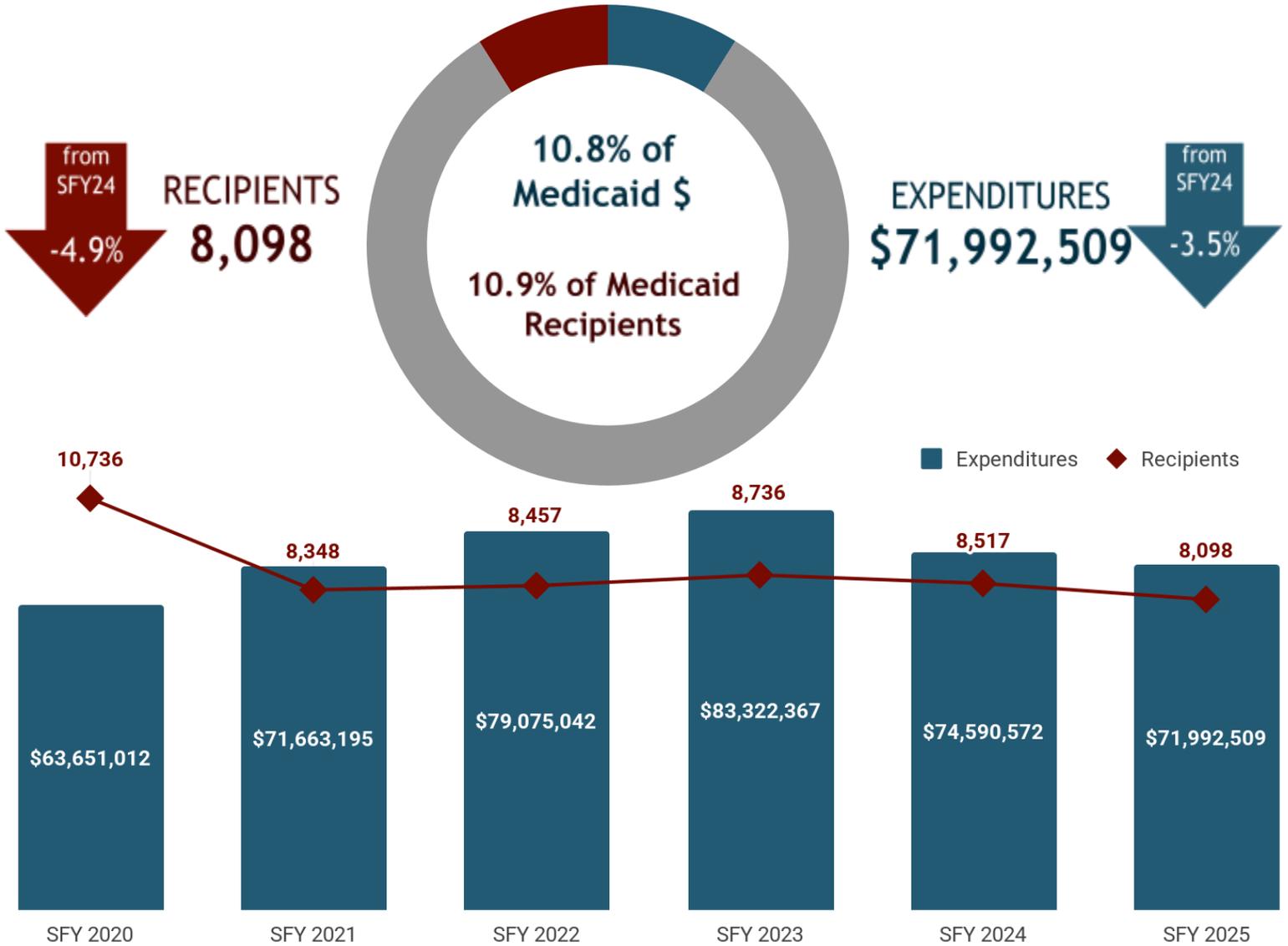


Table 26. Hospital Inpatient Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$63,651,012	\$71,663,195	\$79,075,042	\$83,322,367	\$74,590,572	\$71,992,509	13.1
Recipients	10,736	8,348	8,457	8,736	8,517	8,098	-24.6
Expenditures Per Recipient	\$5,929	\$8,584	\$9,350	\$9,538	\$8,758	\$8,890	50.0



HOSPITAL - OUTPATIENT

Medicaid covers outpatient hospital services, including emergency room, surgery, laboratory, radiology, and other testing services. For individuals over age 21, visits to hospital outpatient departments are limited to a maximum of 12 per calendar year. There are no limits for Medicare crossovers, children under age 21, visits for family planning, Health Check services, and emergency room.

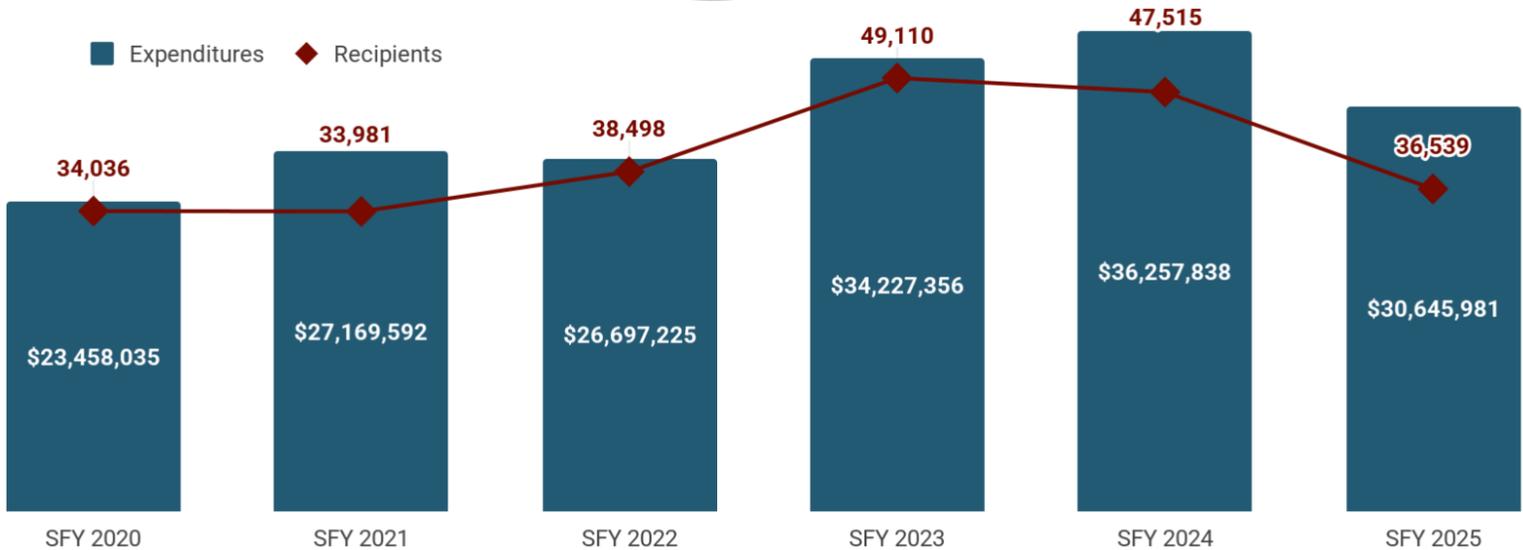
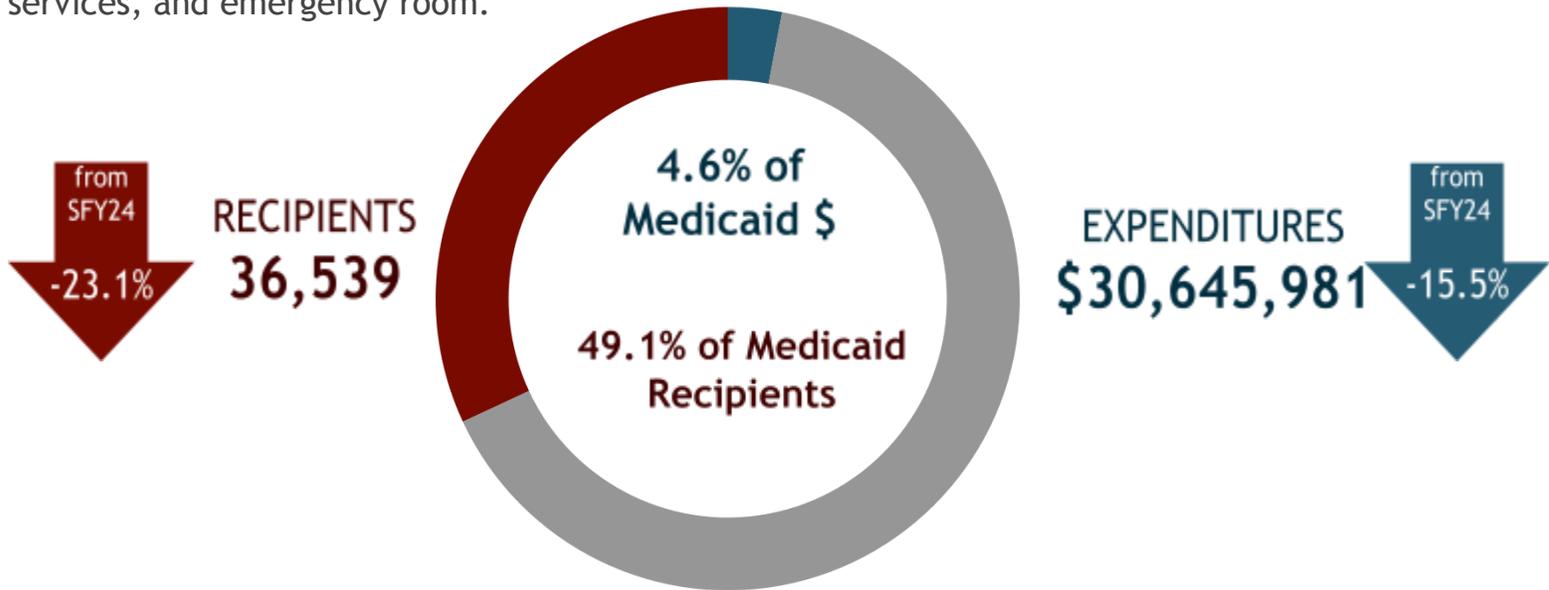


Table 27. Hospital Outpatient Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$23,458,035	\$27,169,592	\$26,697,225	\$34,227,356	\$36,257,838	\$30,645,981	30.6
Recipients	34,036	33,981	38,498	49,110	47,515	36,539	7.4
Expenditures Per Recipient	\$689	\$800	\$693	\$697	\$763	\$839	21.7



EMERGENCY ROOM SERVICES

This data excludes those visits that result in an inpatient admission for both visit count and expenditures. Total ER expenditures include the total amount paid on claims with a line indicating treatment in the ER. This change was made to include the cost of laboratory, radiology, and other tests that may not be performed in the ER setting, but are still associated with the ER visit.

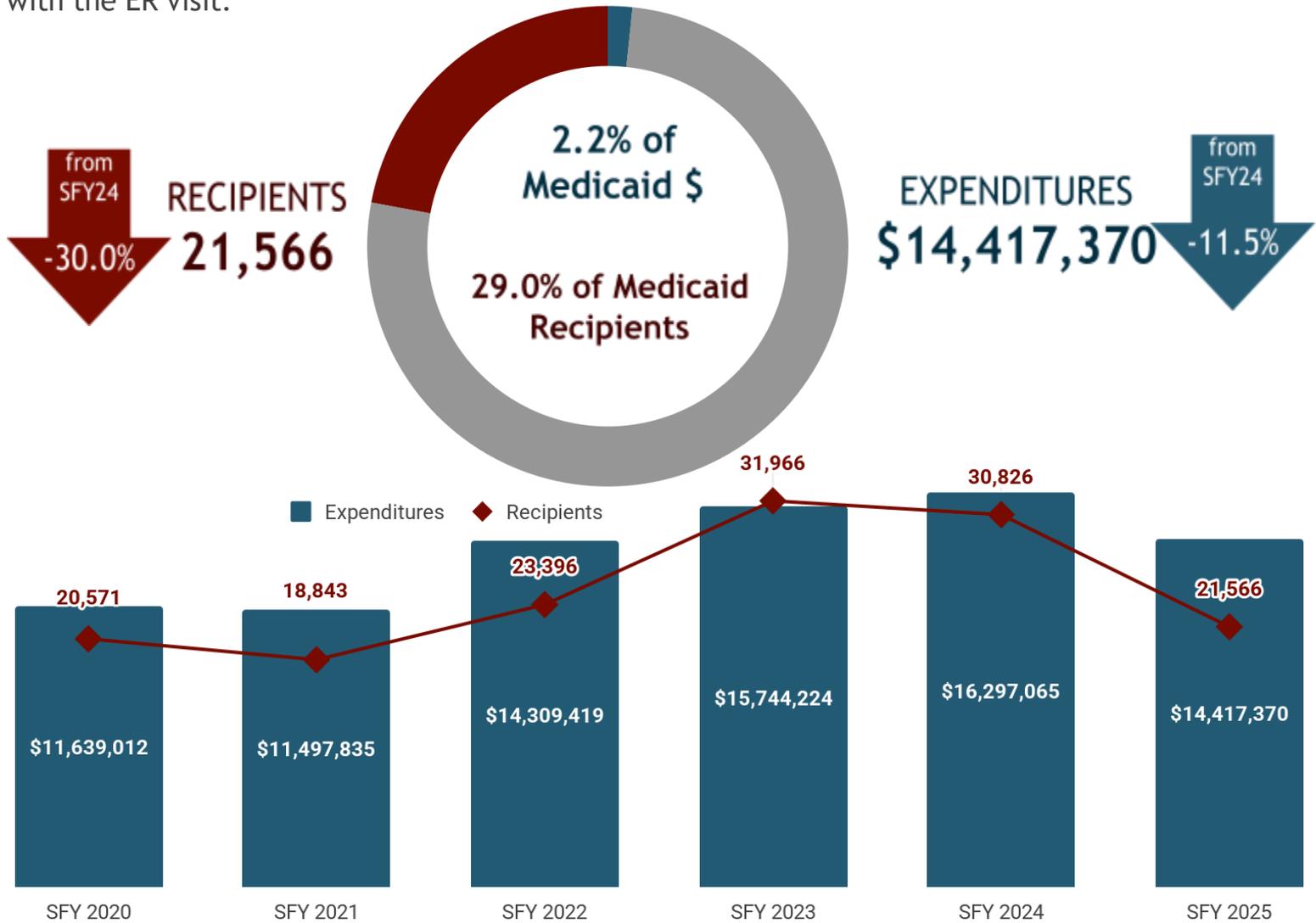


Table 28. Emergency Room Service Utilization History

Claim Paid Date	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$11,639,012	\$11,497,835	\$14,309,419	\$15,744,224	\$16,297,065	\$14,417,370	23.9
Recipients	20,571	18,843	23,396	31,966	30,826	21,566	4.8
Expenditures per Recipient	\$566	\$610	\$612	\$493	\$529	\$669	18.2

Table 29. Emergency Room Utilization by Eligibility Category

Eligibility Category	SFY 2025 Expenditures	% Change from SFY 2024	SFY 2025 Recipients ¹⁴	% Change from SFY 2024	SFY 2025 Expenditures per Recipient	% Change from SFY 2024
ABD EID	\$21,999	-36.0	72	-55.0	\$306	42.2
ABD ID/DD/ABI	\$446,603	13.3	805	-18.2	\$555	38.5
ABD Institution	\$9,941	79.2	12	-40.0	\$828	198.7
ABD Long-Term Care	\$609,144	-16.3	1,700	-29.6	\$358	18.9
ABD SSI & SSI Related	\$2,087,716	-10.3	2,182	-30.3	\$957	28.8
Adults	\$3,102,981	-18.2	3,026	-40.5	\$1,025	37.5
Children	\$6,245,441	-10.6	10,701	-29.9	\$584	27.6
Children's Health Insurance Program	\$545,724	26.9	984	-4.3	\$555	32.6
Medicare Savings Programs	\$98,964	-19.7	949	-29.9	\$104	14.6
Non-Citizens with Medical Emergencies	\$48,907	2.9	45	-52.1	\$1,087	115.0
Pregnant Women	\$1,171,562	-16.1	1,500	-30.5	\$781	20.7
Special Groups	\$28,388	-7.3	28	-34.9	\$1,014	42.3
Totals	\$14,417,370	-11.5	22,004	-30.7	\$655	27.6

¹⁴ This column displays a distinct count of recipients for each eligibility category, as well as the total distinct count of recipients. Summing the recipients for each eligibility category will not match the total recipients as individuals may receive services under multiple eligibility categories throughout the SFY.



INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID)

Services are covered only in a residential facility licensed and certified by the state survey agency as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Wyoming Life Resource Center is the sole facility in the state. This service is unique to Medicaid and is not commonly covered by other payers.

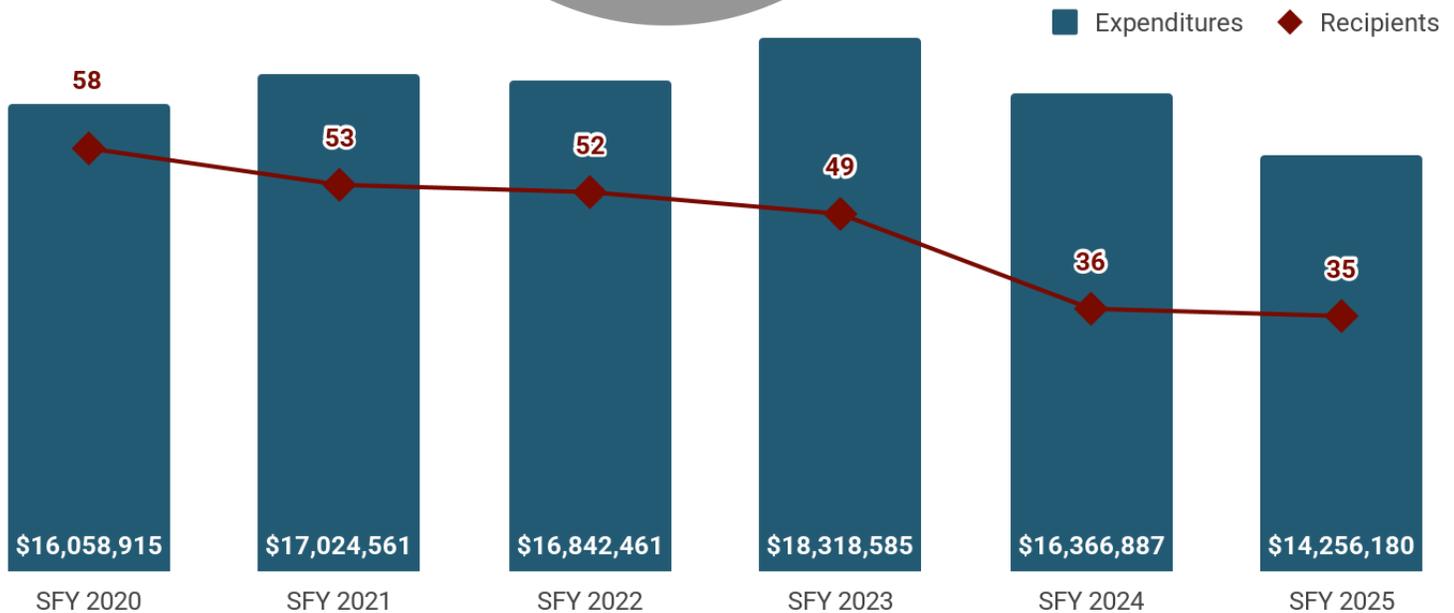
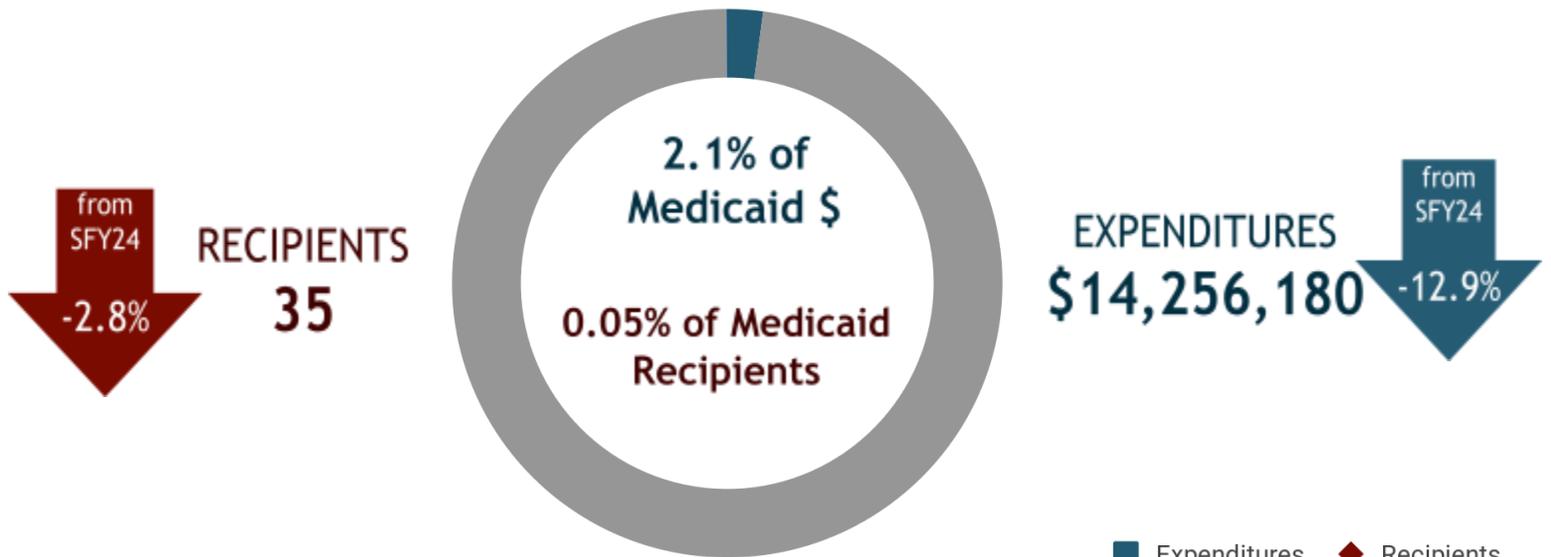


Table 30. ICF-IID Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$16,058,915	\$17,024,561	\$16,842,461	\$18,318,585	\$16,366,887	\$14,256,180	-11.2
Recipients	58	53	52	49	36	35	-39.7
Expenditures Per Recipient	\$276,878	\$321,218	\$323,893	\$373,849	\$454,636	\$407,319	47.1



LABORATORY

Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and its treatment.

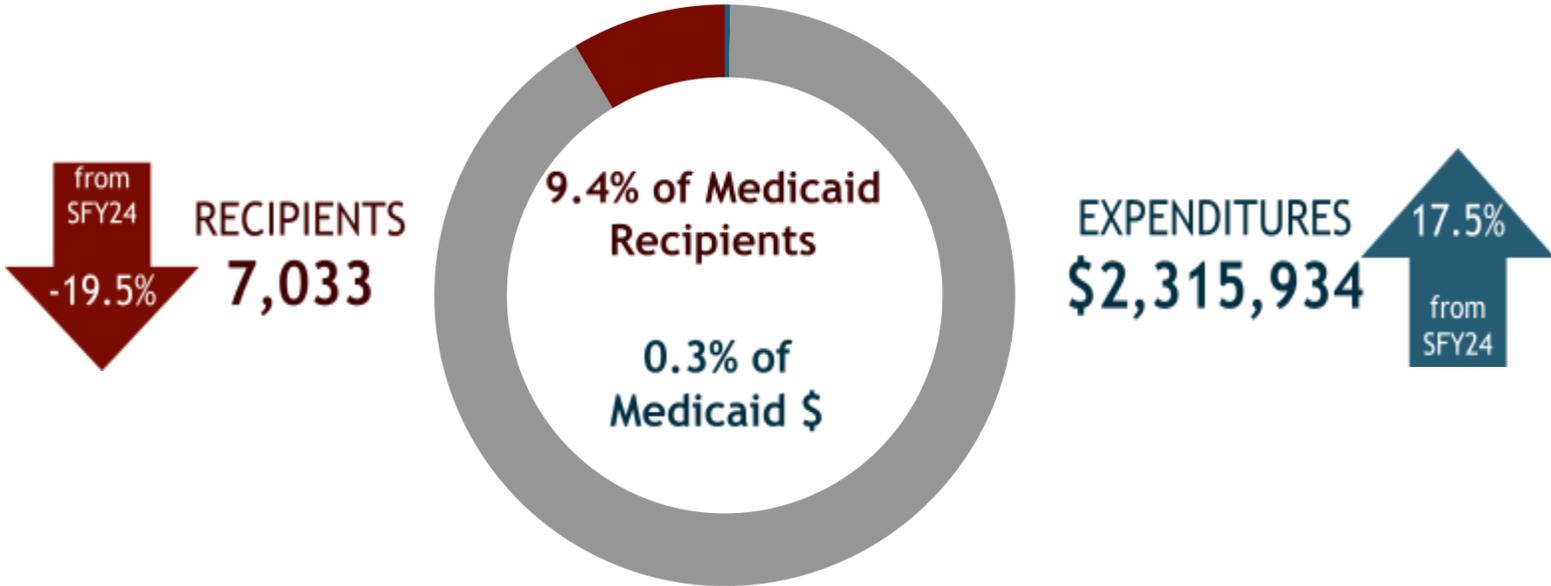


Table 31. Laboratory Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$585,977	\$810,495	\$1,078,644	\$1,817,952	\$1,970,386	\$2,315,934	295.2
Recipients	5,967	7,277	7,924	8,172	8,735	7,033	17.9
Expenditures Per Recipient	\$98	\$111	\$136	\$222	\$226	\$329	235.3



NURSING FACILITY

Skilled Nursing Facilities (SNF) provide long term care to members who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities. Swing Bed services are those long-term care services provided in the hospital setting in place of transferring the member to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

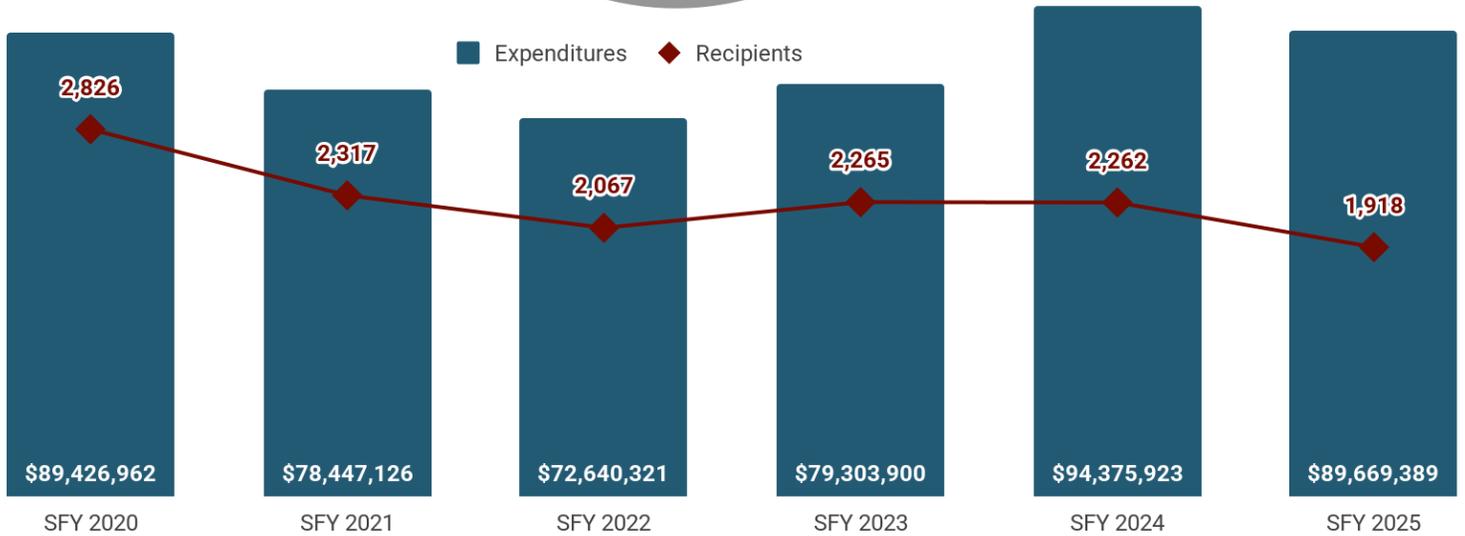
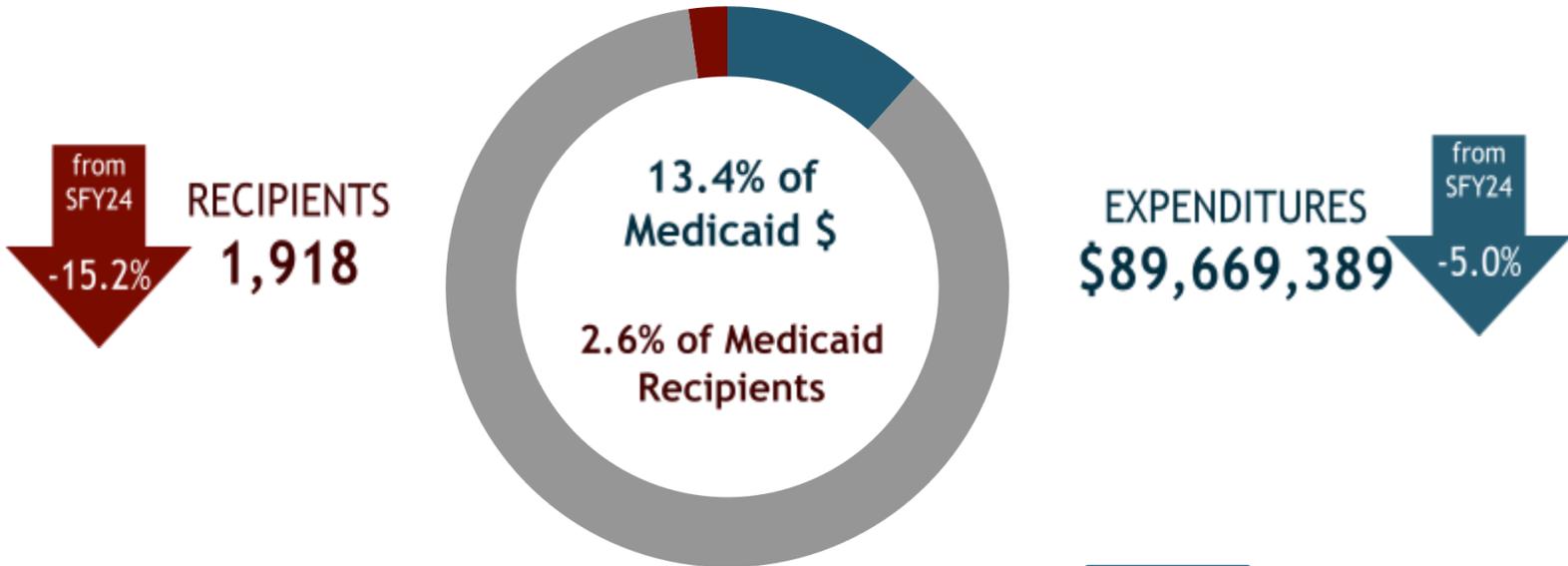


Table 32. Nursing Facilities Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$89,426,962	\$78,447,126	\$72,640,321	\$79,303,900	\$94,375,923	\$89,669,389	0.3
Recipients	2,826	2,317	2,067	2,265	2,262	1,918	-32.1
Expenditures Per Recipient	\$31,644	\$33,857	\$35,143	\$35,013	\$41,722	\$46,752	47.7

Table 33. Nursing Facility Program Rates and Payments

Rate / Payment	Definition
GAP	<ul style="list-style-type: none"> ● Supplemental payment for non-State-government-owned nursing facilities. ● The total funds available for the distribution will equal the UPL gap remaining after the UPL distributions are made under the existing authority. The undistributed balance will remain available for this distribution program. The state shall distribute the funds based on the percentage total of each provider’s calculation of the difference between what Medicaid paid and what Medicare would have paid, less the original supplemental PL payment, as calculated on the annual UPL demonstration. If this calculation results in the provider having a negative UPL gap, that provider will not qualify for the payment.
Provider Assessment & Upper Limit Payment (UPL)	<ul style="list-style-type: none"> ● Supplemental payment for qualified nursing facilities. ● Based on calculations from most recent cost reports & comparisons to what would have been paid for Medicaid services under Medicare’s payment principles ● Assessment collected on all non-Medicare days & UPL payment paid on Medicaid days once corresponding federal matching dollars are obtained.
Per Diem Rate	<ul style="list-style-type: none"> ● Based on facility-specific cost reports ● May not exceed the maximum rate established by Medicaid <ul style="list-style-type: none"> ○ Includes: <ul style="list-style-type: none"> ■ Routine services (room, dietary, laundry, nursing, minor-medical surgical supplies, non-legend pharmaceutical items, use of equipment & facilities) ■ Therapy services ○ Excludes: <ul style="list-style-type: none"> ■ Physician visits, hospitalizations, laboratory, x-rays, and prescription drugs which are reimbursed separately
Extraordinary Care Per Diem Rate	<ul style="list-style-type: none"> ● Paid for services provided to a resident with extraordinary needs ● Medicaid determines per-case rates for extraordinary care based on relevant cost and a review of medical records ● Provided to encourage nursing facilities to accept adults who require individualized psychiatric care



PHYSICIAN & OTHER PRACTITIONER

Services provided by physicians and other practitioners, with limits:

- Hospital outpatient departments, physician offices, and optometrist offices - maximum of 12 visits per calendar year for individuals over age 21. Additional visits can be approved after referral to care management programs and review for medical necessity.
- Physical, occupational, and speech therapy - maximum of 20 visits each per calendar year for individuals over age 21, with additional visits approved after review for medical necessity.

There is no limit for Medicare crossovers or children under age 21; also, no limit for family planning visits, Health Check services, or emergency services.

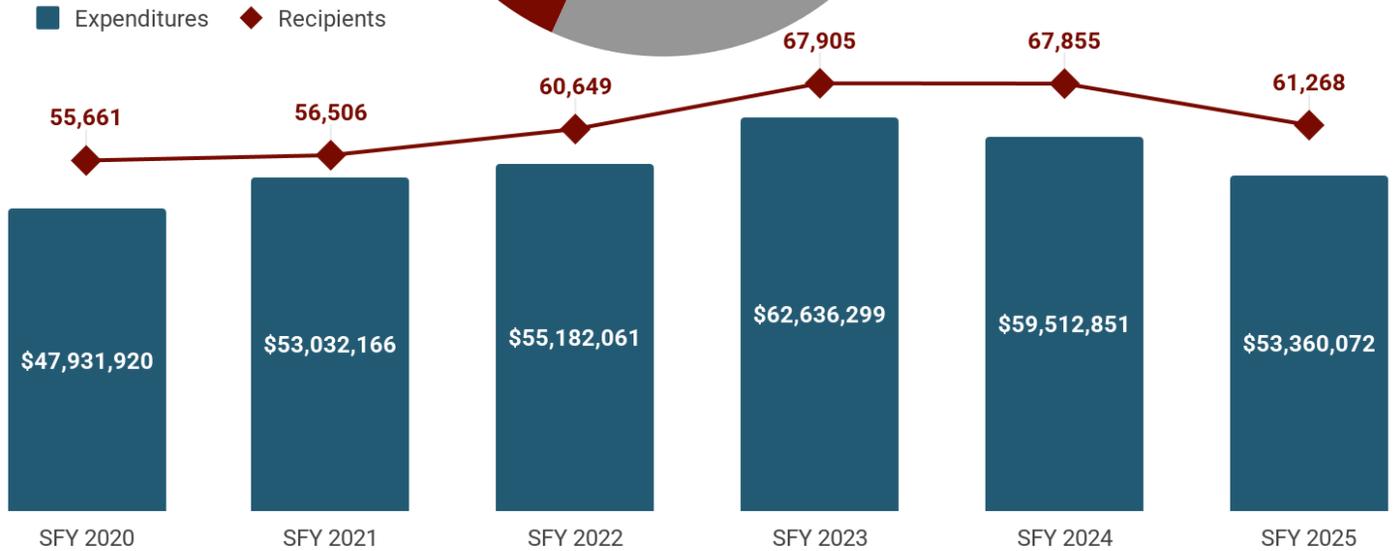
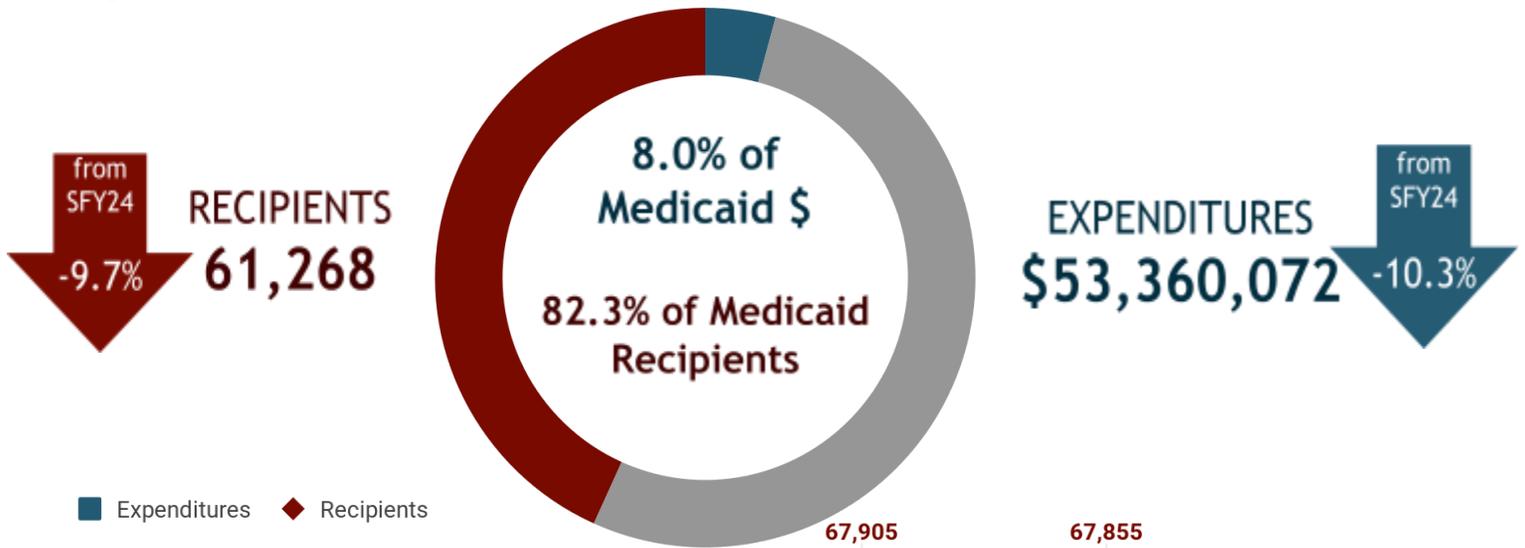


Table 34. Physician and Other Practitioner Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$47,931,920	\$53,032,166	\$55,182,061	\$62,636,299	\$59,512,851	\$53,360,072	11.3
Recipients	55,661	56,506	60,649	67,905	67,855	61,268	10.1
Expenditures Per Recipient	\$861	\$939	\$910	\$922	\$877	\$871	1.1

Other Practitioners Include:

- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Podiatrists
- Nurse Practitioners
- Nurse Midwives
- Nurse Anesthetists
- Audiologists
- Chiropractors

Resource-based Relative Value Scale

- ★ Used to reimburse medical services provided by physicians, physician assistants, physical and occupational therapists, ophthalmologists, and nurse practitioners.
- ★ Based on estimates of the costs of resources required to provide physician services using a relative value unit (RVU) and conversion factor.
 - $RVU \times Conversion\ Factor = \text{fee schedule rate}$
- ★ RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, taking into consideration the time and intensity of the physician's effort, and the physician's practice and malpractice expenses.
- ★ Services provided by anesthesiologists are reimbursed using RVUs developed and published by the American Society of Anesthesiologists.



PRESCRIPTION DRUGS

Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription is required for all drugs for most individuals. Exceptions may apply for specific products or conditions.

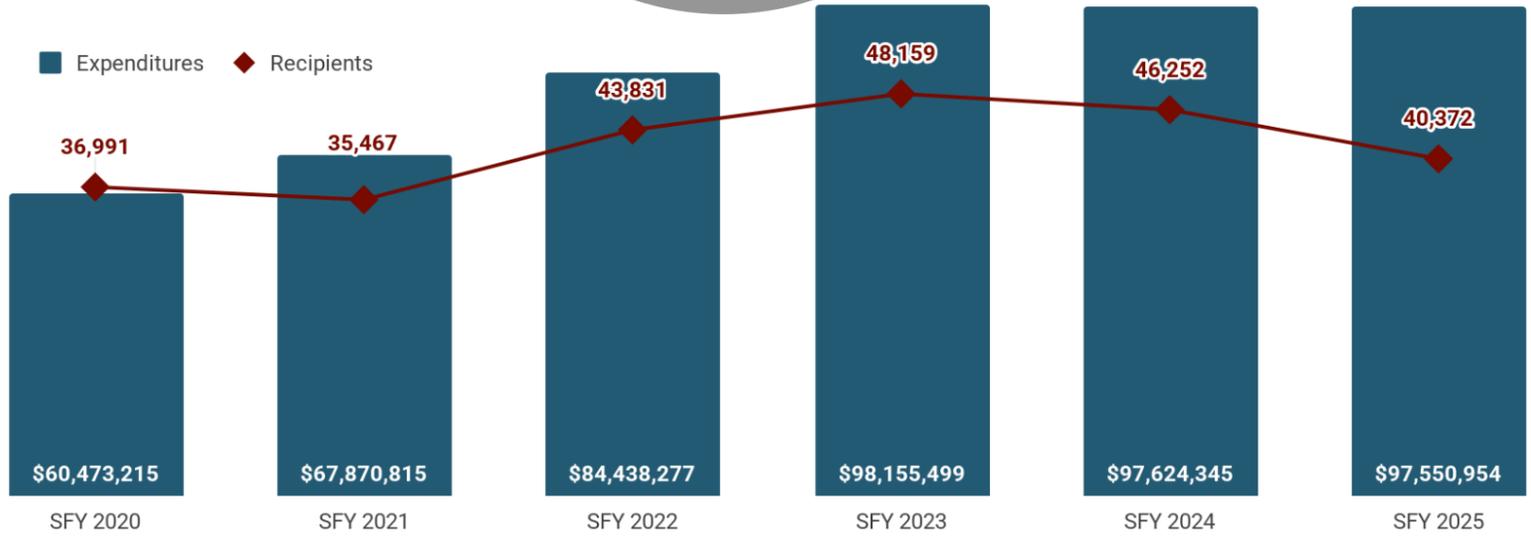
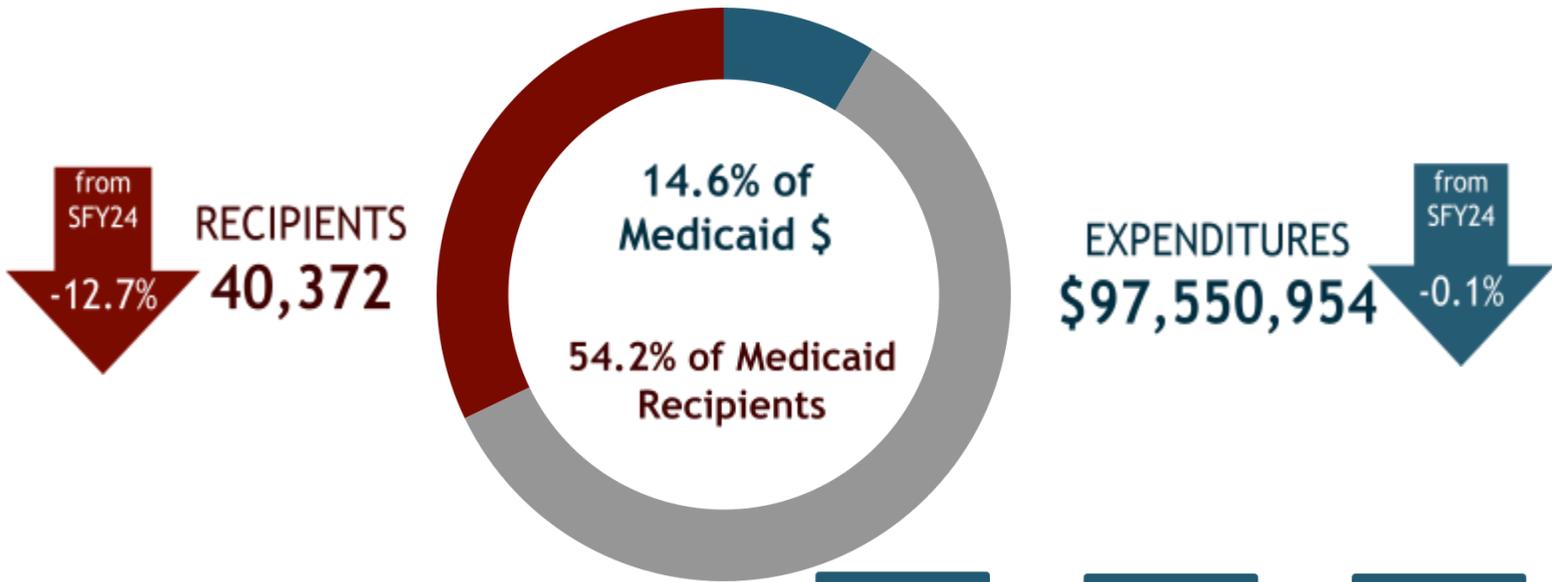


Table 35. Prescription Drugs Service Utilization History¹⁵

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$60,473,215	\$67,870,815	\$84,438,277	\$98,155,499	\$97,624,345	\$97,550,954	61.3
Recipients	36,991	35,467	43,831	48,159	46,252	40,372	9.1
Expenditures Per Recipient	\$1,635	\$1,914	\$1,926	\$2,038	\$2,111	\$2,416	47.8

¹⁵ Data includes expenditures for pharmacies only and does not take into account rebate amounts.

Table 36. Pharmacy Cost Avoidance ~ SFY 2025

Program Area	Cost Avoidance
Prior Authorization (PA)	\$13,616,512
Preferred Drug List (PDL)	
% Of Pharmacy Claims paid at State Maximum Allowable Cost Rate	56%
Program Integrity Cost Avoidance	\$2,518,551

150

Specific drug classes designated as preferred drugs in SFY 2025

Drug Utilization Review (DUR) Program ensures individuals receive appropriate medically necessary medications. More information is available in the Subprograms section of this report.

DRUG REBATE PROGRAM

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Requires drug manufacturers have national rebate agreement with HHS Secretary. For a prescription drug to be covered, Medicaid must receive an OBRA rebate for it. This federal mandate provides Medicaid the opportunity to receive greatly discounted products, similar to those offered to large purchases in the marketplace. Medicaid is a member of the Sovereign States Drug Consortium (SSDC), a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA.

Table 37. Prescription Drug - Rebates History¹⁶

Claim Paid Date SFY	Rebate (millions)
SFY 2015	\$20.1
SFY 2016	\$31.4
SFY 2017	\$27.7
SFY 2018	\$30.4
SFY 2019	\$29.3
SFY 2020	\$27.2
SFY 2021	\$33.5
SFY 2022	\$38.6
SFY 2023	\$43.5
SFY 2024	\$40.5
SFY 2025 ¹⁷	\$26.8

TOTAL DRUG REBATES

\$4.2m + \$26.8m = \$31.0 million

of J-code rebates for physician-administered or injectable drugs *of outpatient drug rebates*

¹⁶ J code rebates are mandated by the Deficit Reduction Act of 2005.

¹⁷ As a result of an error that occurred in SFY 2025 that could not be corrected until SFY 2026, SFY 2025 is lower than expected and SFY 2026 will likely be higher than expected.



PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

Medicaid covers psychiatric residential treatment for individuals under the age of 21 at a Psychiatric Residential Treatment Facility (PRTF), a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents under the direction of a physician, with a goal of improving the resident’s condition, or preventing further regression so services will no longer be needed.

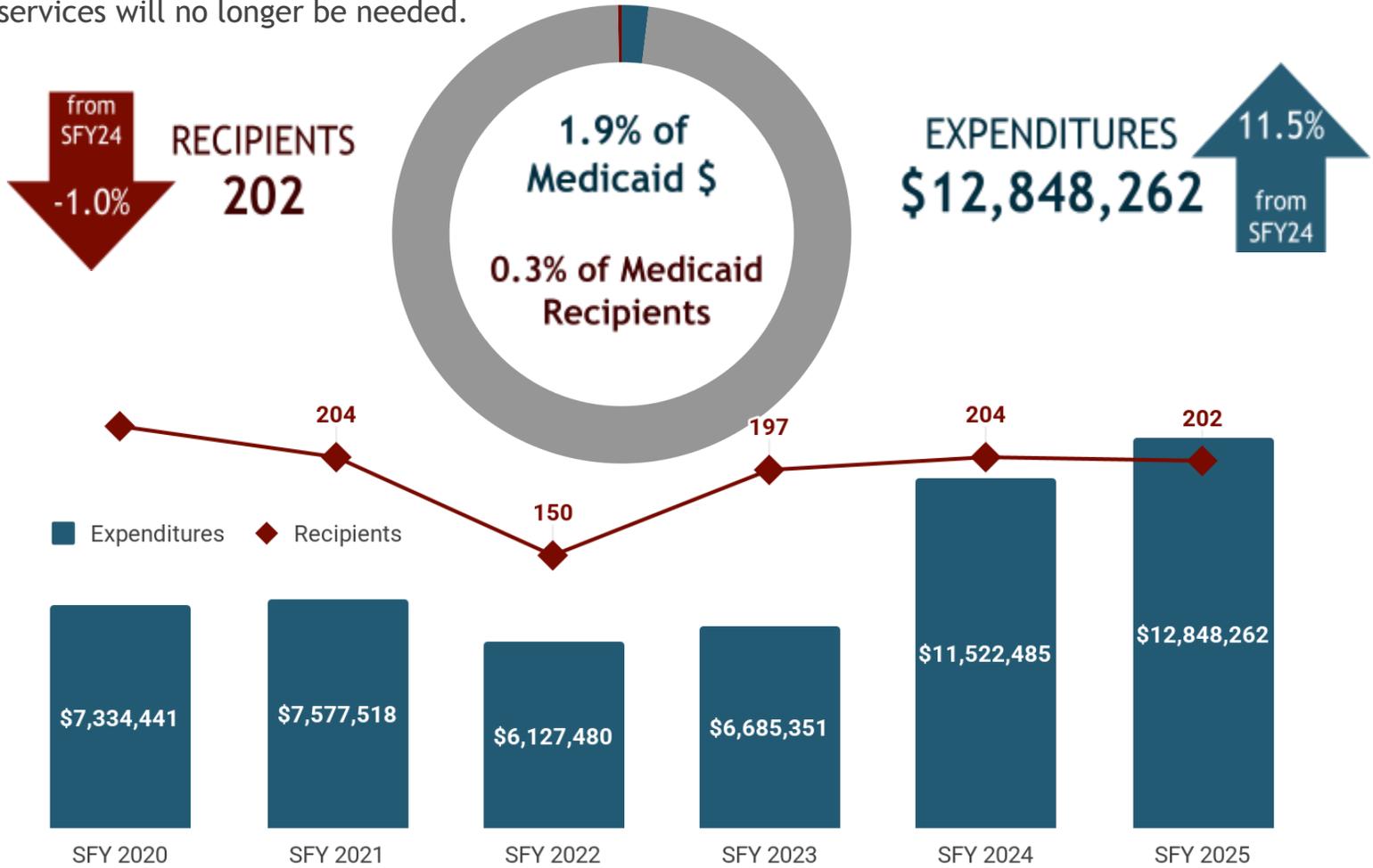


Table 38. PRTF Service Utilization History¹⁸

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$7,334,441	\$7,577,518	\$6,127,480	\$6,685,351	\$11,522,485	\$12,848,262	75.2
Recipients	221	204	150	197	204	202	-8.6
Expenditures Per Recipient	\$33,188	\$37,145	\$40,850	\$33,936	\$56,483	\$63,605	91.7

¹⁸ Most PRTF placements qualify for federal Medicaid match. However, 100% State General Funds (SGF) are used if a PRTF placement is determined to no longer meet medical necessity, after a clinical review and determination. A transition period of up to thirty days may be authorized permitting time for the necessary court hearings, multidisciplinary team meetings, and court orders to be updated. Upon expiration of an approved transition, no further reimbursement shall be authorized.



PUBLIC HEALTH OR WELFARE

Physician and mid-level practitioner (Public Health Nurses) services are provided in a clinic designated by the Department of Health as a public health clinic.

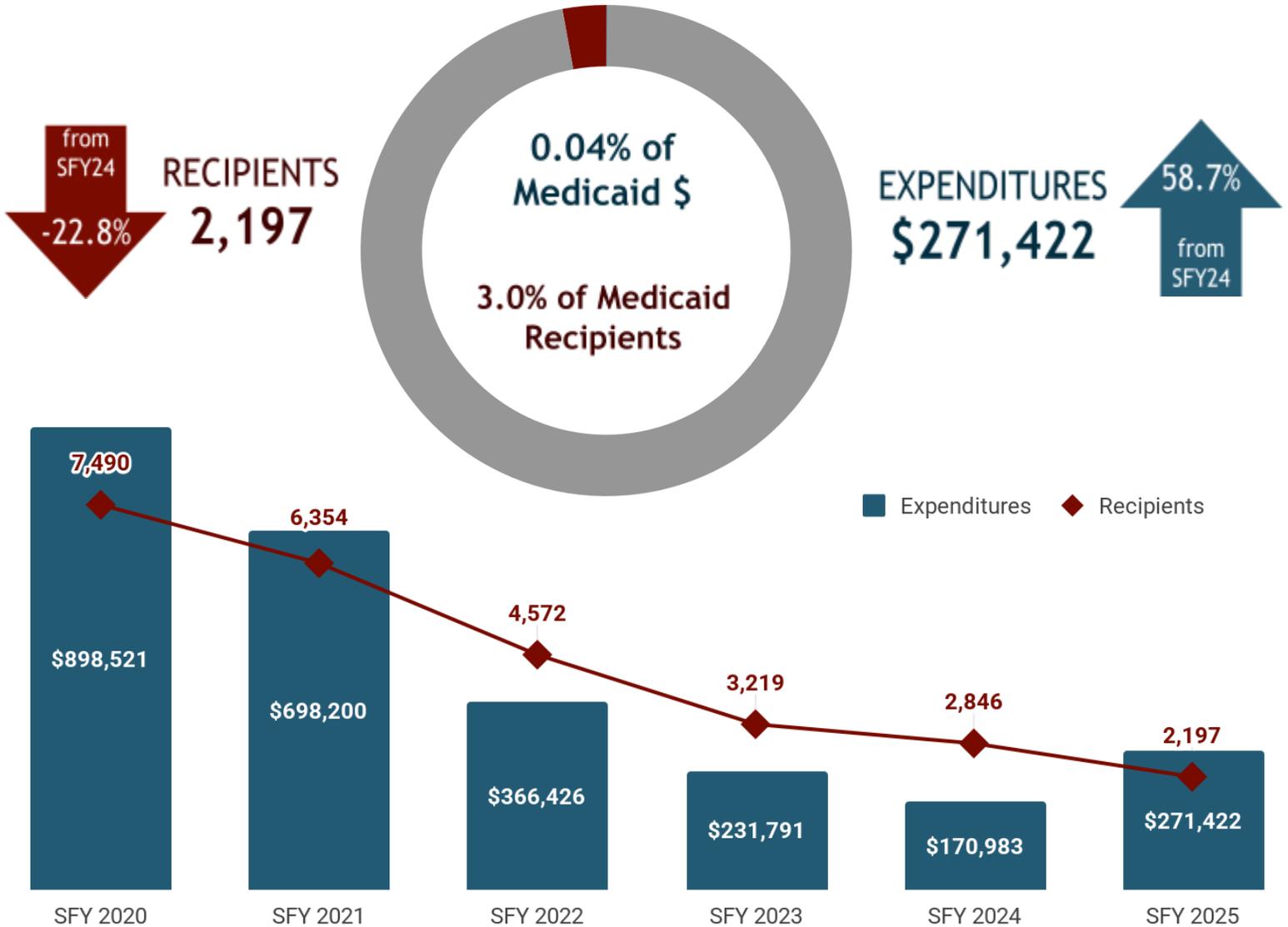


Table 39. Public Health or Welfare Service Utilization History¹⁹

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$898,521	\$698,200	\$366,426	\$231,791	\$170,983	\$271,422	-69.8
Recipients	7,490	6,354	4,572	3,219	2,846	2,197	-70.7
Expenditures Per Recipient	\$120	\$110	\$80	\$72	\$60	\$124	3.0

¹⁹ LT-101 Level of Care Assessments shifted from a claim based process to an administrative (invoice) process in July of 2021, resulting in a decline of expenditures and recipients for subsequent state fiscal years.



PUBLIC HEALTH, FEDERAL

These services are provided to the American Indian/Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing comprehensive primary care and related services to those who are of the American Indian/Alaska Native Population. Services provided by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

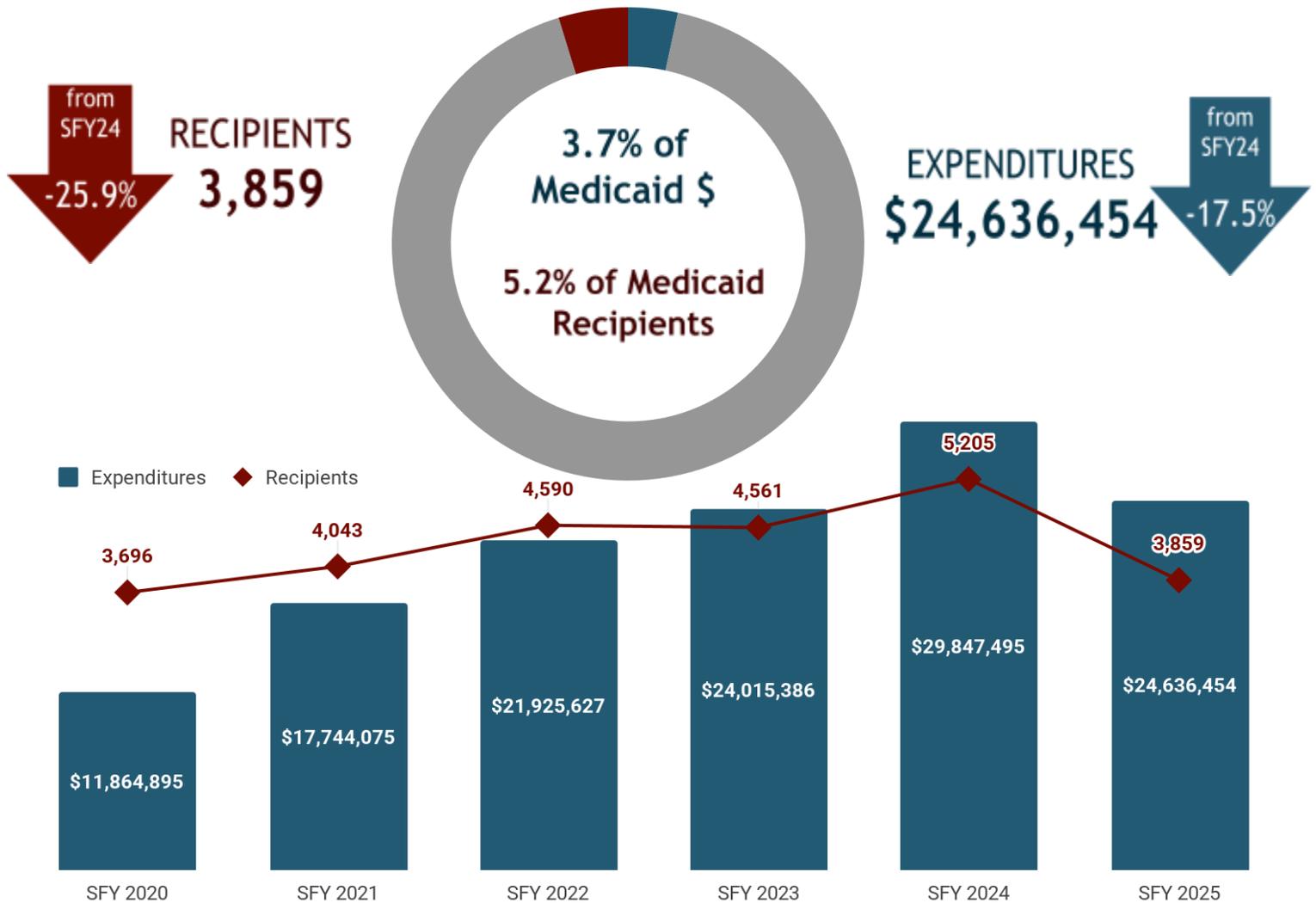


Table 40 Public Health Federal Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$11,864,895	\$17,744,075	\$21,925,627	\$24,015,386	\$29,847,495	\$24,636,454	107.6
Recipients	3,696	4,043	4,590	4,561	5,205	3,859	4.4
Expenditures Per Recipient	\$3,210	\$4,389	\$4,777	\$5,265	\$5,734	\$6,384	98.9



RURAL HEALTH CLINIC

Primary care services are provided at a Rural Health Clinic, as designated by Medicare if it is located in a “shortage area”, a geographic area designated by the HHS as having a shortage of personal health services or primary medical care professionals. Medicaid covers services provided by a physician, nurse practitioner, certified nurse midwife, clinical psychologist, certified social worker, dentist, orthodontist, and physician assistant, as well as services and supplies incident to a physician’s service.

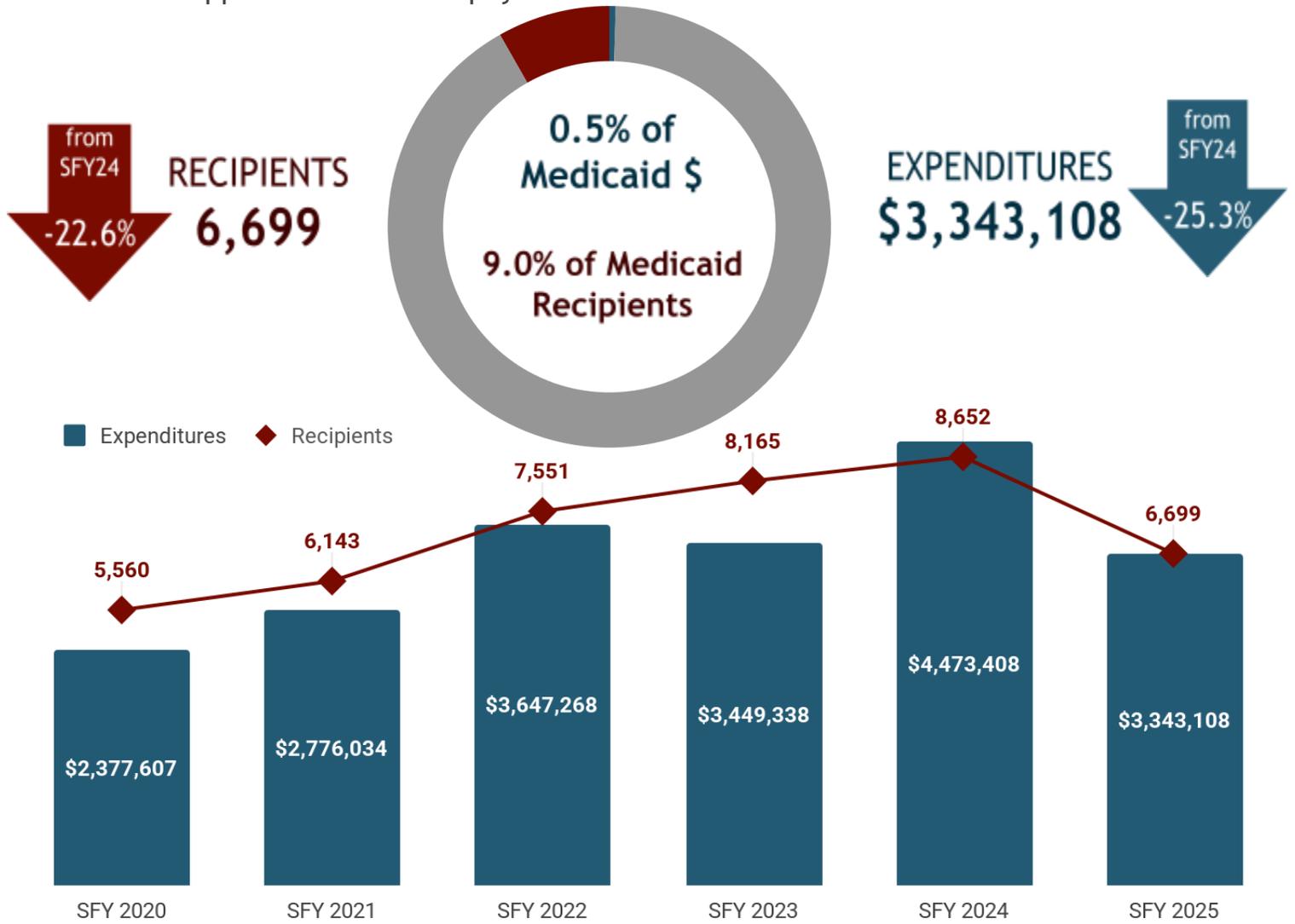


Table 41. Rural Health Clinic Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$2,377,607	\$2,776,034	\$3,647,268	\$3,449,338	\$4,473,408	\$3,343,108	40.6
Recipients	5,560	6,143	7,551	8,165	8,652	6,699	20.5
Expenditures Per Recipient	\$428	\$452	\$483	\$422	\$517	\$499	16.7



VISION

Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists, with services dependent on recipient age. Children receive services to correct and maintain healthy vision, including eyeglasses (frames, frame parts, and lenses) and vision therapy based on diagnosis codes. Adults may receive services to treat an eye injury or eye disease. Vision services provided by ophthalmologists are included in the Physician and Other Practitioners section of this report.

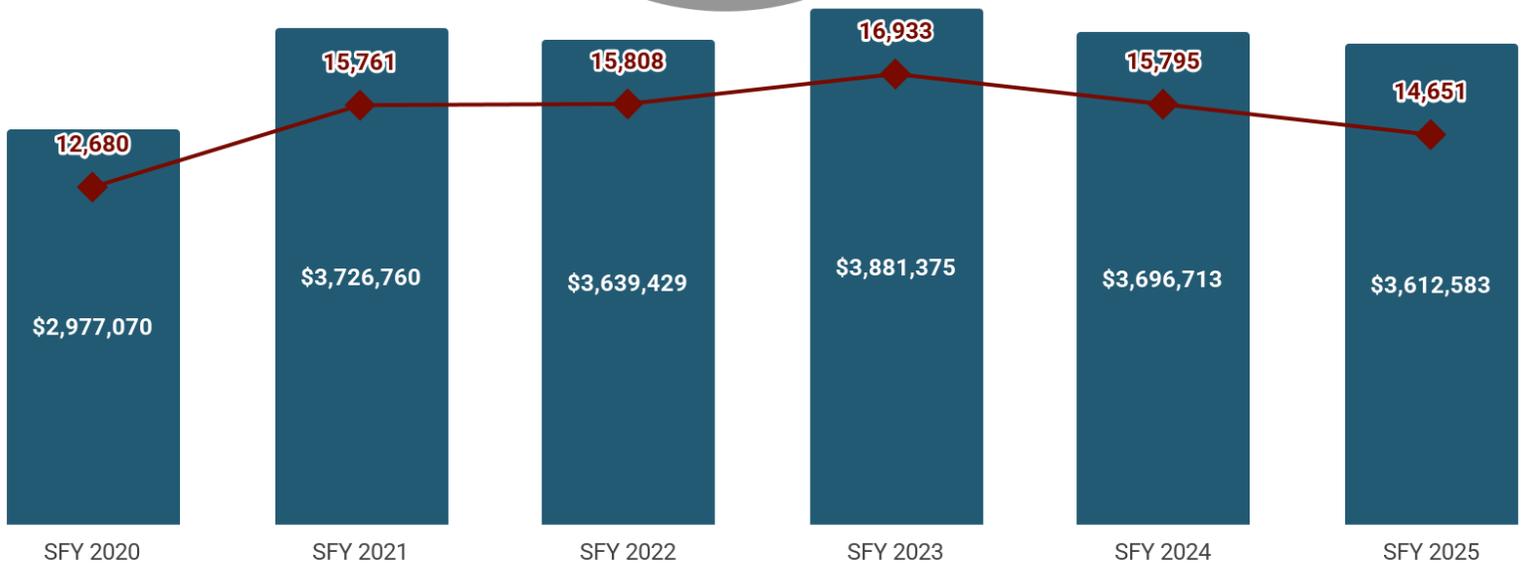
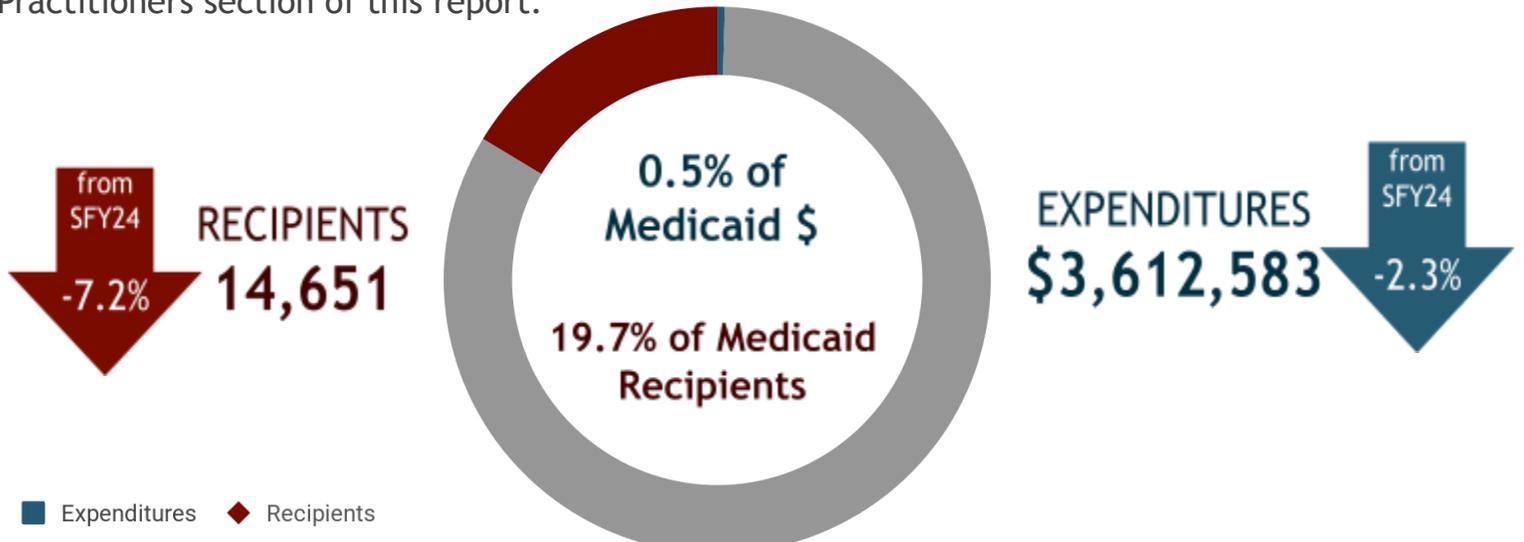


Table 42. Vision Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$2,977,070	\$3,726,760	\$3,639,429	\$3,881,375	\$3,696,713	\$3,612,583	21.3
Recipients	12,680	15,761	15,808	16,933	15,795	14,651	15.5
Expenditures Per Recipient	\$235	\$236	\$230	\$229	\$234	\$247	5.0



WAIVERS - COMMUNITY CHOICES

This waiver provides in-home services and assisted living services to Medicaid enrollees 19 - 64 years of age who are aged, blind, or disabled or 65 years of age or older and require services equivalent to nursing home level of care.

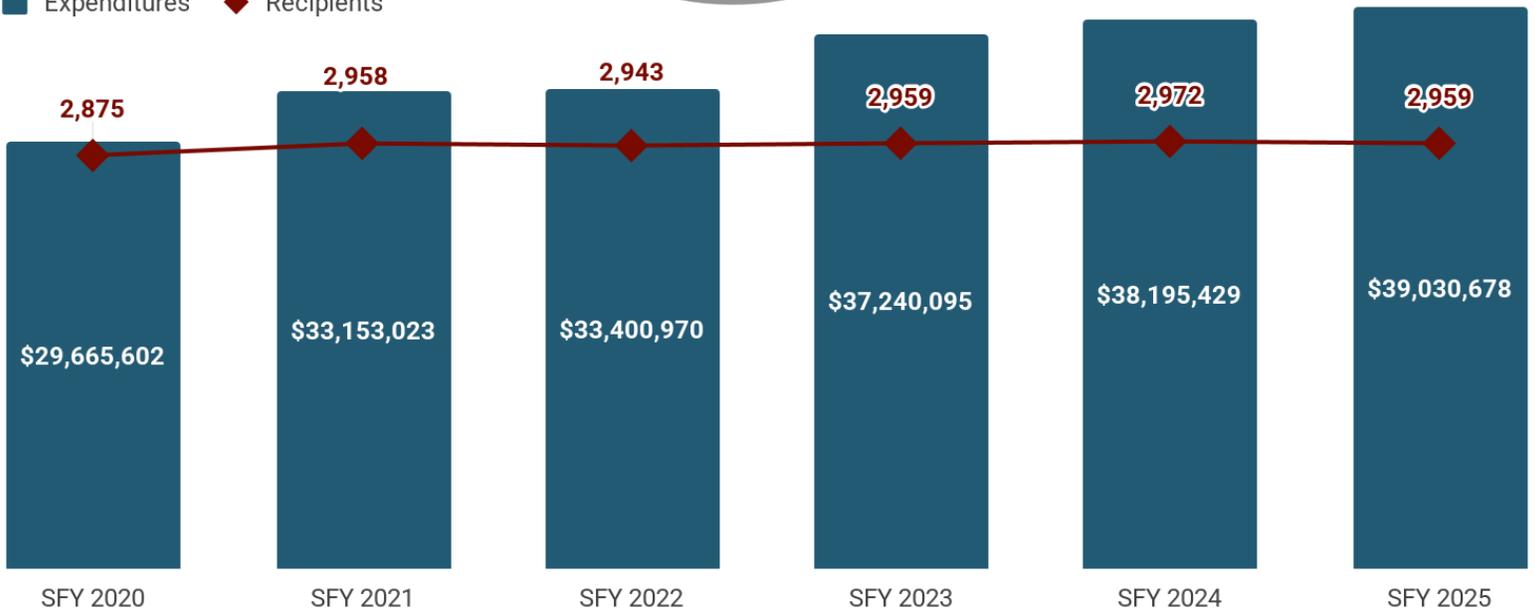
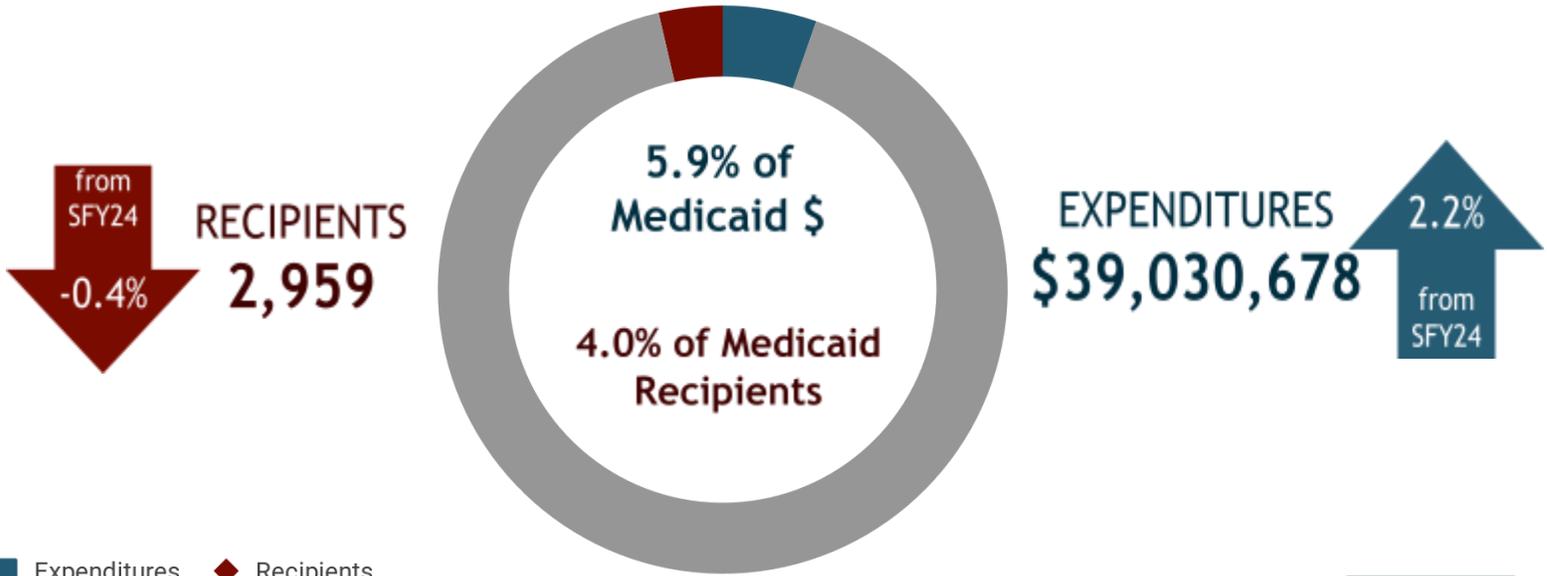


Table 43. Waivers - Community Service Center Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$29,665,602	\$33,153,023	\$33,400,970	\$37,240,095	\$38,195,429	\$39,030,678	31.6
Recipients	2,875	2,958	2,943	2,959	2,972	2,959	2.9
Expenditures Per Recipient	\$10,318	\$11,208	\$11,349	\$12,585	\$12,852	\$13,190	27.8



WAIVERS - COMPREHENSIVE

This Medicaid waiver, started in SFY 2014, funds services for individuals with intellectual or developmental disability based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool. The Comprehensive Waiver provides services to qualifying people of all ages who have an intellectual disability, or an acquired brain injury. However, individuals must meet additional emergency criteria to receive services under this waiver.

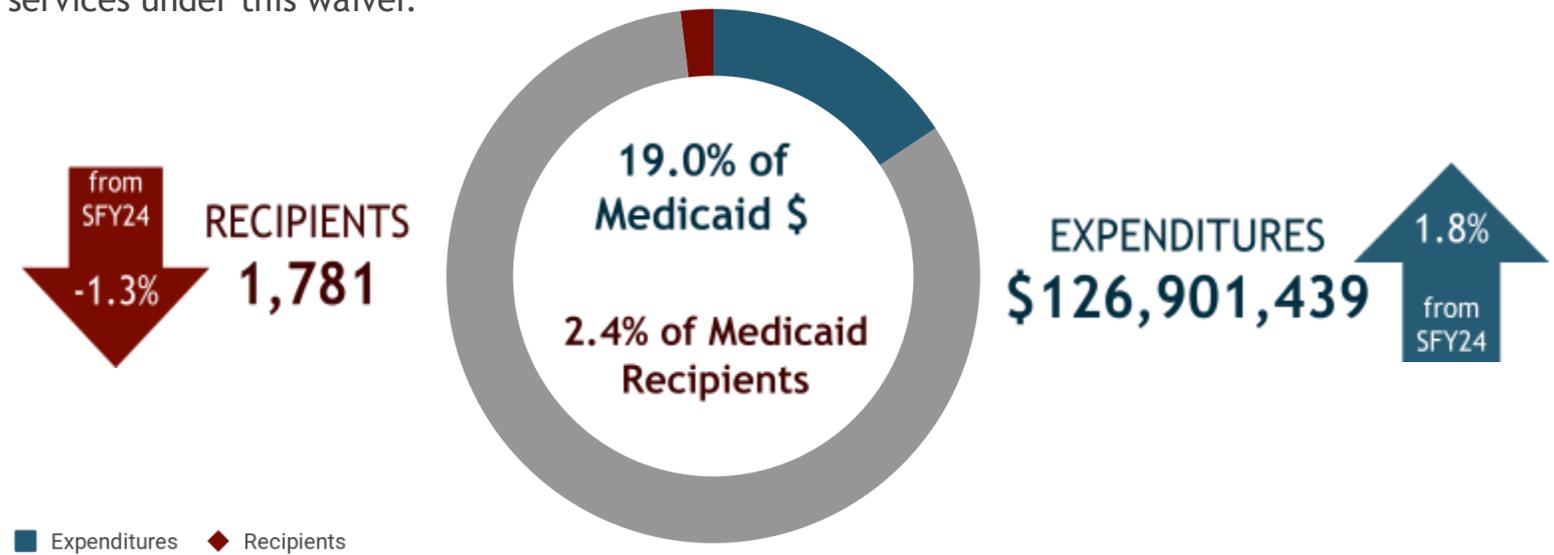


Table 44. Comprehensive Waivers Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$113,532,461	\$114,273,065	\$108,465,328	\$117,851,552	\$124,600,967	\$126,901,439	11.8
Recipients	1,932	1,892	1,866	1,840	1,804	1,781	-7.8
Expenditures Per Recipient	\$58,764	\$60,398	\$58,127	\$64,050	\$69,069	\$71,253	21.3



WAIVERS - SUPPORT

The Supports Waiver helps people of all ages who have an intellectual disability or ages 21-64 with an acquired brain injury. It offers a limited budget for purchasing personalized services.

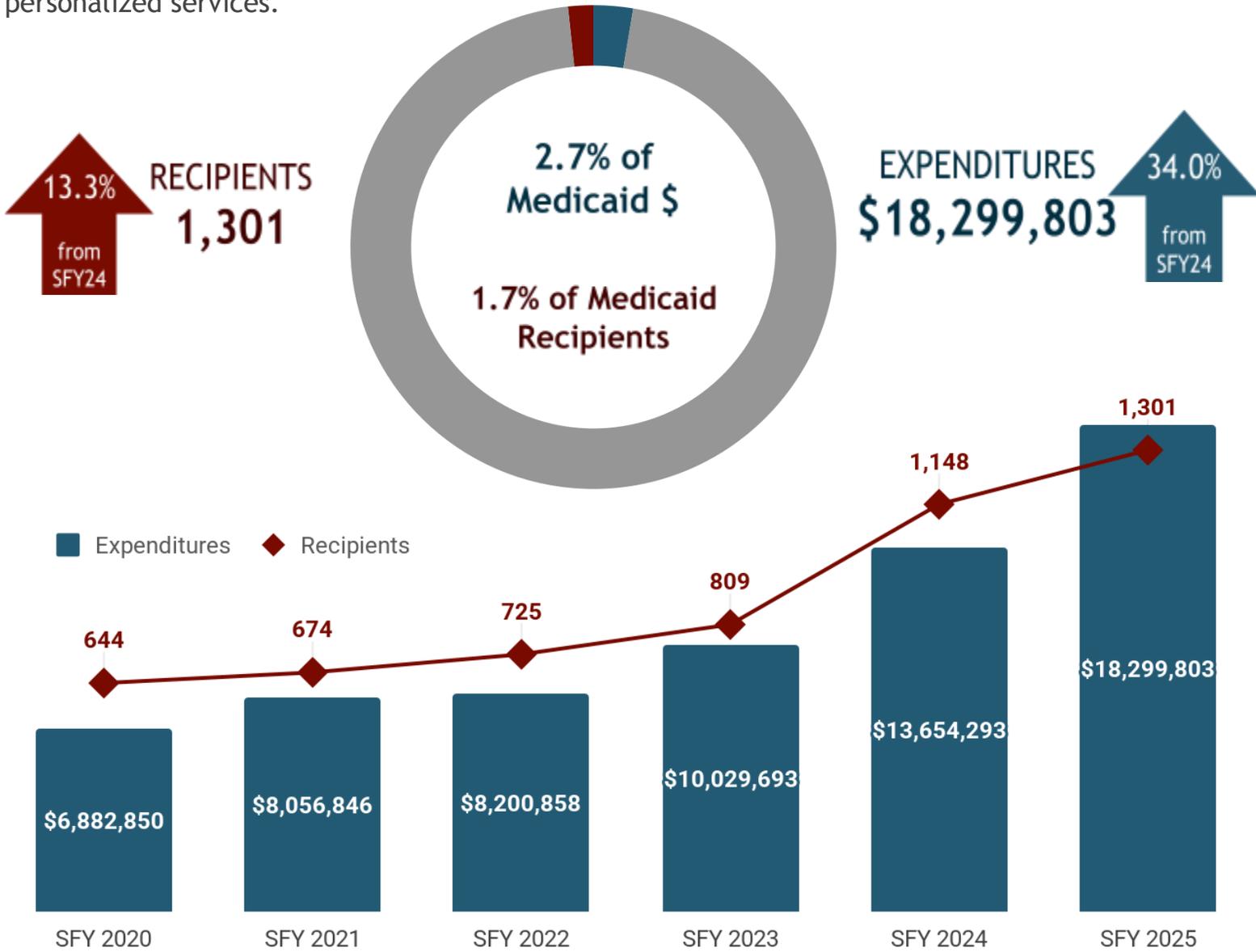


Table 45. Supports Waiver Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$6,882,850	\$8,056,846	\$8,200,858	\$10,029,693	\$13,654,293	\$18,299,803	165.9
Recipients	644	674	725	809	1,148	1,301	102.0
Expenditures Per Recipient	\$10,688	\$11,954	\$11,312	\$12,398	\$11,894	\$14,066	31.6



WAIVERS - PREGNANT BY CHOICE

Medicaid provides pregnancy planning services through this Section 1115 waiver with the goal of reducing the incidence of closely spaced pregnancies and decreasing the number of unintended pregnancies in order to reduce health risks to women and children and achieve cost savings. These services are available to women who have received Medicaid benefits under the Pregnant Women eligibility program and would otherwise lose Medicaid eligibility 12 months postpartum.

Recipient Counts < 10 are redacted to protect the privacy of Wyoming Medicaid clients.

0.0002% of Medicaid \$
0.011% of Medicaid Recipients

EXPENDITURES
\$1,431
↑ 35.9%
from SFY24



Table 46. Family Planning Waiver Service Utilization History²⁰

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$1,428	\$0	\$1,988	\$1,697	\$1,053	\$1,431	0.2
Recipients	< 10	< 10	< 10	< 10	< 10	< 10	--

²⁰ Pregnant by Choice waiver services are included in the individual service sections in this report and are thus excluded from the service overview tables earlier in the report.

SUBPROGRAMS & SPECIAL POPULATIONS

DRUG UTILIZATION REVIEW



The Drug Utilization Review (DUR) program reviews the utilization of outpatient prescription drugs to ensure individuals are receiving appropriate, medically necessary medications which are not likely to result in adverse effects. The program was established in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). Medicaid has contracted with the University of Wyoming to administer the program, which includes a number of activities, as described below.

Pharmacy & Therapeutics Committee

Six physicians, five pharmacists, and one allied health professional along with the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and a drug information specialist from the University of Wyoming School of Pharmacy. Meets quarterly to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review, and education activities to Medicaid.

Prospective DUR

Required review of prescription claims for appropriateness prior to dispensing at the pharmacy. This review takes prior authorization policies into consideration when identifying potential issues, including, but not limited to, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and potential adverse effects.

Retrospective DUR

Ongoing review of aggregate claims data to uncover trends and review individual patient profiles to aid in monitoring for therapeutic appropriateness, over-and under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and other issues. This can lead to recommendations for prospective DUR policy, including prior authorizations, to encourage appropriate utilization at the program level. Reviewing individual patient profiles may result in educational letters to the prescriber when the reviewing Committee members determine the issue to be clinically significant to a specific patient.

Input from Medical Committee

Actively solicits feedback about prior authorization policies from prescribers in Wyoming through direct mailings. Letters are sent to all specialists in affected areas, as well as a random sample of fifty general practitioners. The P&T Committee reviews all comments that are received prior to giving final approval of the policy. This allows providers an opportunity to participate in the decision-making process. Providers are encouraged to submit comments and concerns to the committee for review through public comment forms available on the DUR website. Providers may use this method to comment on both existing and new policy.

Education

Quarterly newsletters are sent to all Wyoming providers. Targeted education letters regarding duplicate benzodiazepine utilization, long and short-acting opiate utilization, and high-dose opiate utilization are also sent.

Review Clinical Evidence

The P&T Committee reviews evidence regarding the comparative safety and efficacy of medications, making recommendations to Medicaid for each reviewed class and providing input on clinical considerations included in the creation of the Medicaid Preferred Drug List (PDL).



WYOMING FRONTIER (WYFI) HEALTH INFORMATION EXCHANGE

The WYFI Health Information Exchange (HIE) system enables and supports Medicaid providers in promoting a healthier Wyoming by developing a secure, connected, and coordinated statewide health IT system that supports effective and efficient healthcare. For additional information refer to the WYFI HealthStat documentation.

Table 47. WYFI HealthStat Outcomes

Outcomes	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Facilities - Data Contributing	92	189	217	227	284	294
Facilities - View Only	100	157	165	123	133	102
Unique Providers	386	3,556	3,551	3,486	244	50
Total WYFI Users	939	5,446	5,552	5,555	739	378
WY Covered Lives in the HIE	271,741	357,359	452,915	556,602	643,107	706,289
All Covered Lives in the HIE	303,541	402,304	550,651	678,739	777,566	886,090
Medicaid Covered Lives in the HIE	N/A	N/A	34,171	43,145	62,013	72,325
# Of Patient Encounters in the HIE	2,485,938	3,668,561	5,525,435	7,927,907	10,712,507	13,701,633
Notify Users - ADTs (Alert, Discharge, Transfer Notifications)	8	62	63	69	43	45



ADMINISTRATIVE TRANSPORTATION

Medicaid covers the cost of transportation to and from medical appointments if the appointment is medically necessary, it is approved by WDH and the least costly mode of transportation is selected. Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided. Per diem expenses are reimbursable to family/legal guardian for recipients under age 21 for expanded services. This covers meals and commercial lodging at \$25/day for inpatient and \$50/day for outpatient²¹.

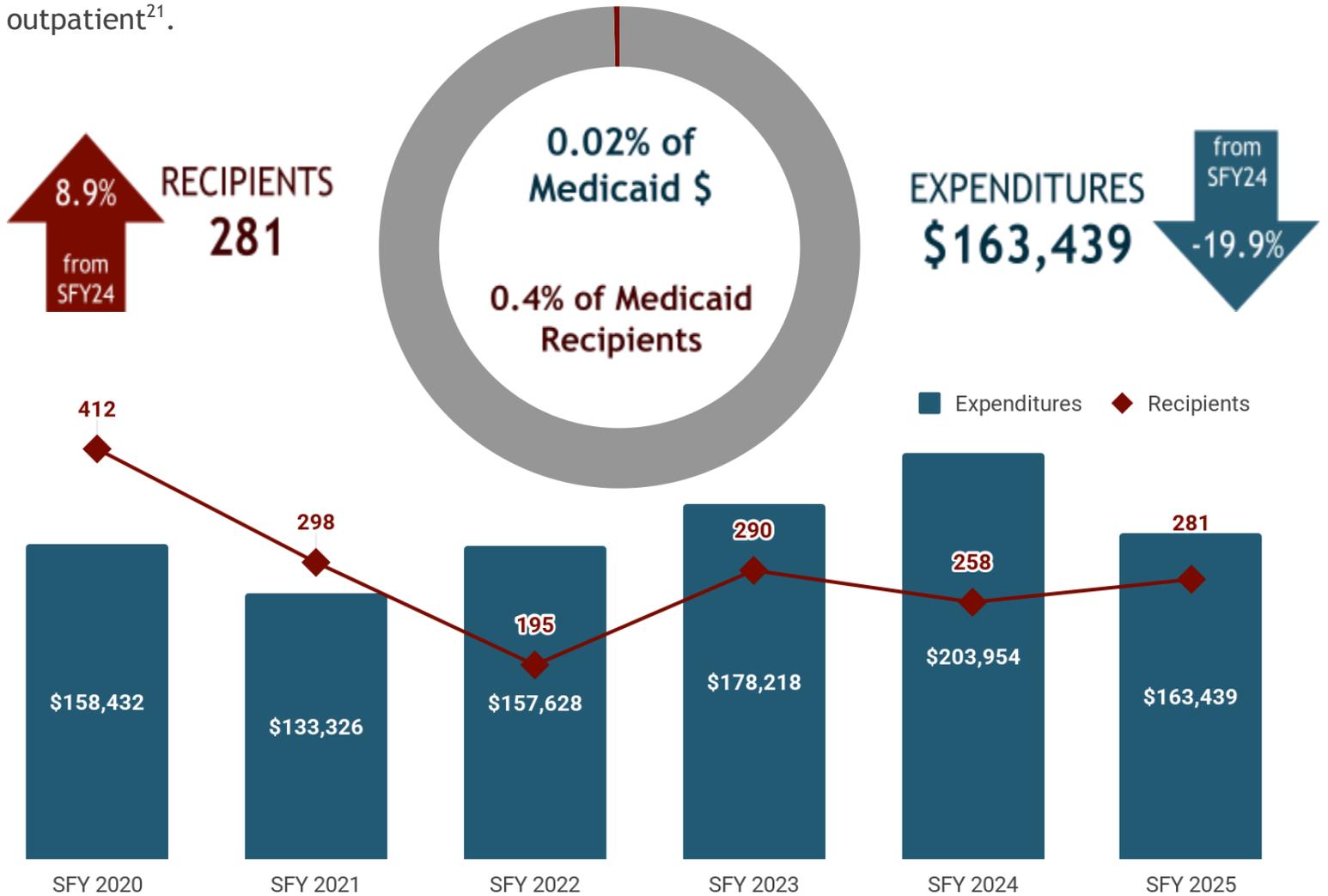


Table 48. Administrative Transportation Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$158,432	\$133,326	\$157,628	\$178,218	\$203,954	\$163,439	3.2
Recipients	412	298	195	290	258	281	-31.8
Expenditures Per Recipient	\$385	\$447	\$808	\$615	\$791	\$582	51.3

²¹ Additional details for other scenarios are available at https://www.wyomingmedicaid.com/portal/Travel_Assistance_Manual.



PATIENT-CENTERED MEDICAL HOME

The PCMH program promotes high-value care using a value-based purchasing model in which health care is coordinated through a primary care physician/practitioner, with a focus on quality and safety. Participating providers are paid a per member per month rate based on their patient volume.

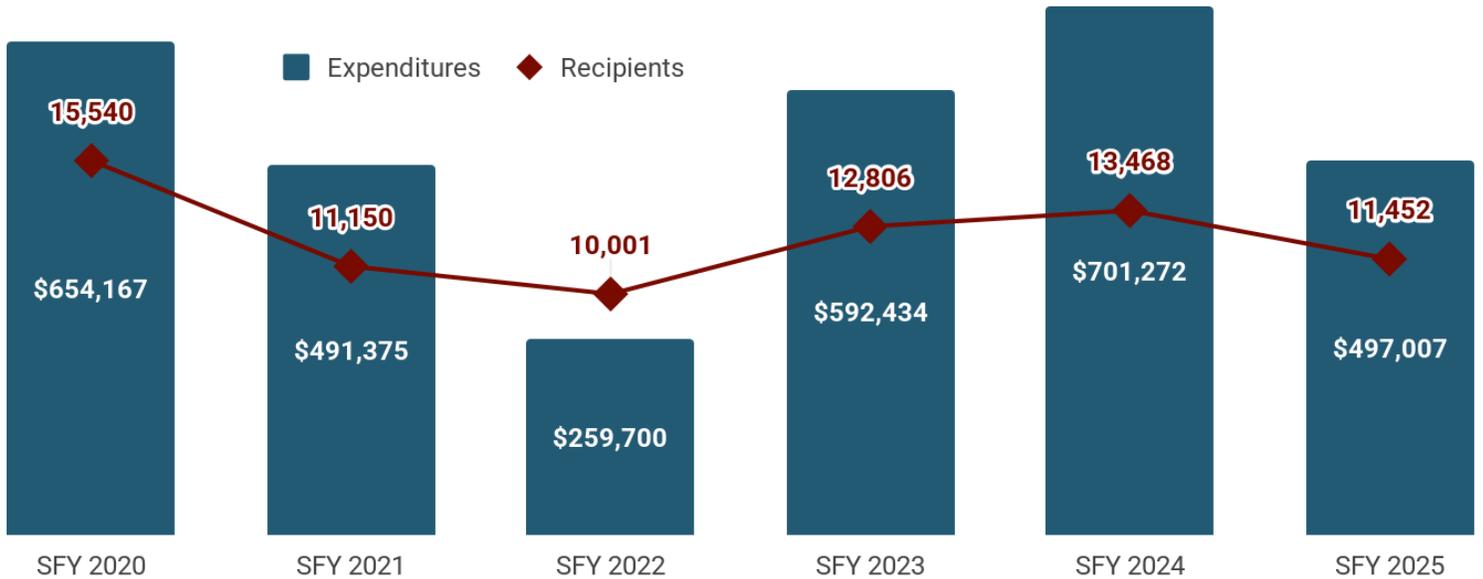
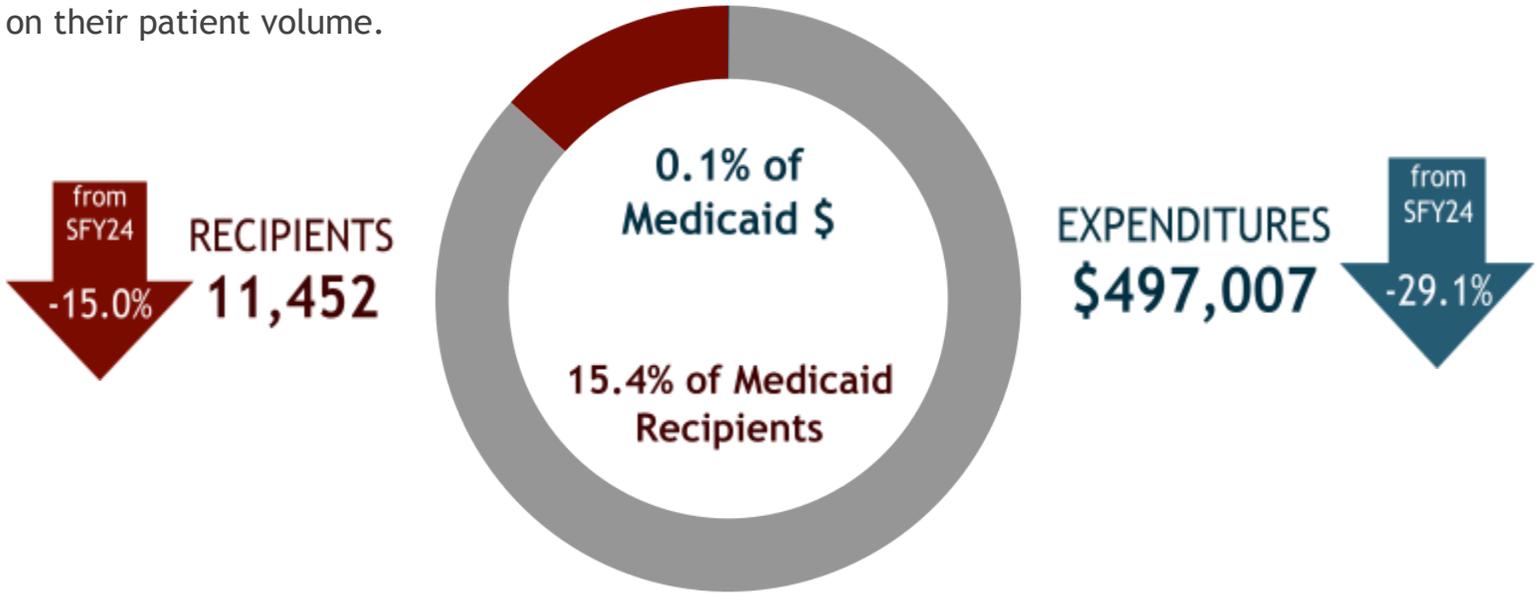


Table 49. PCMH Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Expenditures	\$654,167	\$491,375	\$259,700	\$592,434	\$701,272	\$497,007	-24.0
Recipients	15,540	11,150	10,001	12,806	13,468	11,452	-26.3
Expenditures Per Recipient	\$42	\$44	\$26	\$46	\$52	\$43	3.1



WELL CHILD CHECKS (WCC)

Health Check is a program for children under age 21 that provides the following services under Early, Periodic Screening Detection and Treatment (EPSDT) authority:

- Physical exams
- Immunizations
- Lab tests (blood tests and lead screening)
- Growth and developmental check
- Nutrition check
- Eye exam
- Hearing screening
- Dental screening
- Health information
- Behavioral health assessment
- Other healthcare prescribed by a physician and approved by Medicaid
- Teenage health education
- Transportation (ambulance and administrative)

Medicaid will reimburse all Health Check screening exams and authorized follow-up care and treatment as long as the child is eligible for Medicaid.

Table 50. FFY 2025 Wyoming Medicaid and CHIP Medical and Dental Periodicity Schedules based on Bright Futures²²

	Age Group < 1	Age Group 1 - 2	Age Group 3 - 5	Age Group 6 - 9	Age Group 10 - 14	Age Group 15 - 18	Age Group 19 - 20
Number of Years in Age Range	1	2	3	4	5	4	2
Medical State Periodicity Schedule (Preventative)	7	5	3	4	5	4	2
Dental State Periodicity Scheduled (Preventative, 2 per year)	1	4	6	8	10	8	4

²² Bright Futures, Release 4 periodicity schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf



MEDICAID/MEDICARE DUAL ENROLLED

Individuals with Medicare coverage may also be eligible for Medicaid services, dependent on income. These individuals are referred to as dual enrolled. For these members, Medicare pays first for services covered by both programs, while Medicaid covers additional payments through crossover claims when appropriate. Non-Medicare-covered services are entirely funded by Medicaid, up to Wyoming’s payment limit. This section includes information on both crossover claims services and those services funded entirely by Medicaid. Premium assistance for QMB, SLMB, and QI enrollees is excluded, as these are considered administrative costs.

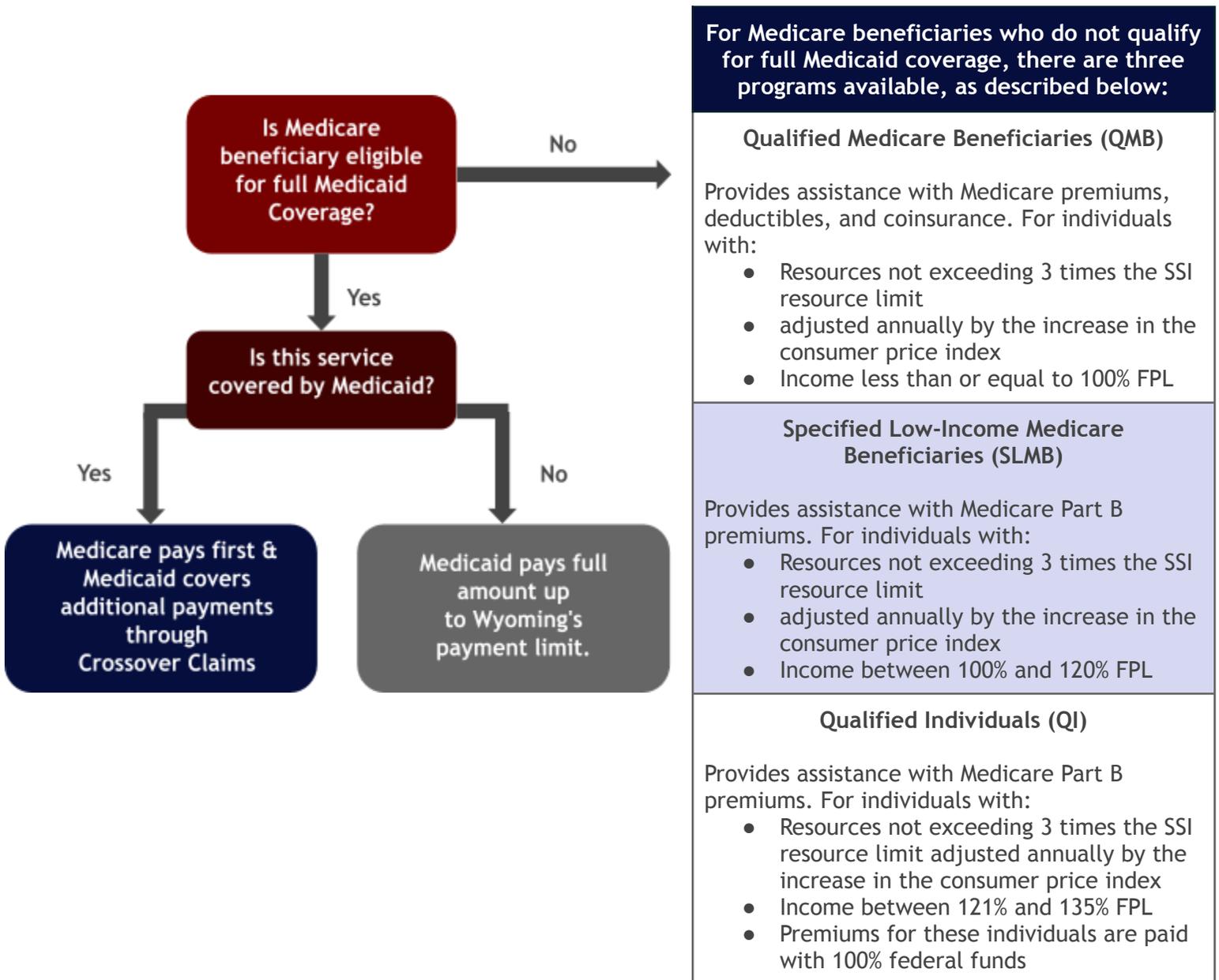


Table 51. Dual Enrolled Members and Crossover Service Utilization History

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Dual Enrolled Members	12,468	12,708	13,187	13,501	14,014	13,953	11.9
Expenditures	\$201,996,786	\$196,893,388	\$186,384,658	\$201,832,501	\$221,781,288	\$221,399,159	9.6
Recipients (unduplicated)	10,356	10,210	10,136	10,940	10,942	10,235	-1.2
Expenditures per Recipient	\$19,505	\$19,284	\$18,388	\$18,449	\$20,269	\$21,632	10.9
Crossover Claim Expenditures	\$7,076,643	\$6,695,318	\$7,054,647	\$9,032,665	\$8,747,564	\$7,559,184	6.8
Crossover Claims - Expenditures as a % of Total Dual Expenditures	3.5%	3.4%	3.8%	4.5%	3.9%	3.4%	-2.5

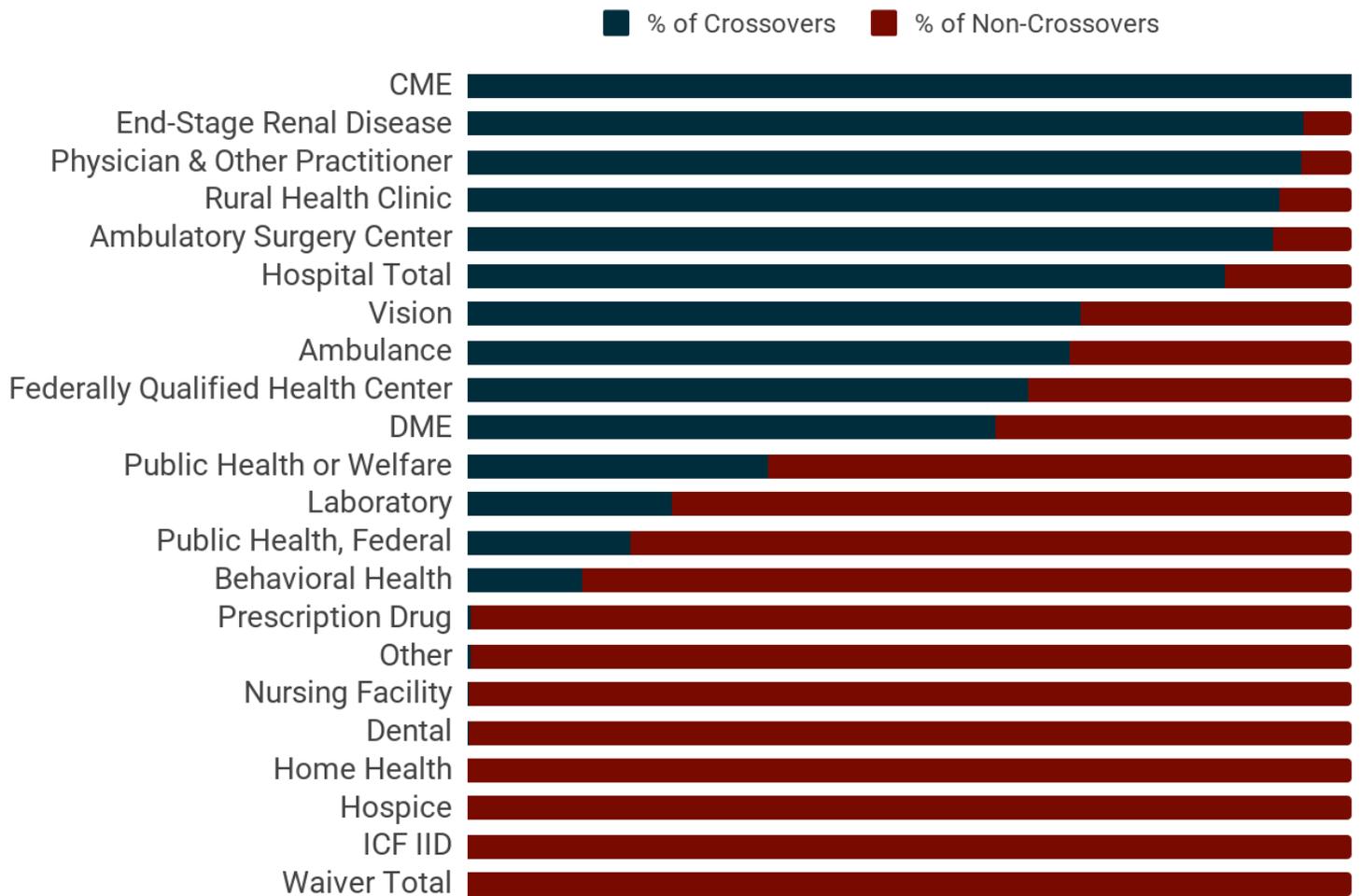


Figure 31. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2025

Table 52. Dual Enrolled Member Service Utilization History²³

Service Area	Total Dual Enrolled			Crossovers		
	Expenditures	Recipients	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	\$36,151	1,255	\$29	\$24,334	1,251	\$19
Ambulatory Surgery Center	\$132,975	735	\$181	\$121,278	726	\$167
Behavioral Health	\$1,040,889	1,695	\$614	\$134,474	1,211	\$111
CME	\$94	< 10	--	\$94	< 10	--
Dental	\$492,495	1,584	--	\$206	< 10	--
DME	\$3,039,192	3,489	\$871	\$1,815,201	3,198	\$568
End-Stage Renal Disease	\$327,629	74	\$4,427	\$310,020	73	\$4,247
Federally Qualified Health Center	\$187,634	1,314	\$143	\$118,925	1,272	\$93
Home Health	\$25,497	112	\$228	\$0	98	\$0
Hospice	\$1,460,821	103	\$14,183	\$0	63	\$0
Hospital - Total	\$1,964,282	6,674	\$294	\$1,711,557	6,648	\$257
Hospital - Inpatient	\$744,455	1,463	\$509	\$623,484	1,447	\$431
Hospital - Outpatient	\$1,219,210	6,512	\$187	\$1,087,599	6,451	\$169
Hospital - Other	\$617	34	\$18	\$475	33	\$14
ICF IID	\$10,069,031	25	\$402,761	--	--	--
Laboratory	\$6,666	954	\$10	\$1,532	937	\$2
Nursing Facility	\$74,935,723	1,532	\$46,553	\$36,526	808	\$45
Other	\$8,380,053	878	\$9,274	\$33,557	327	\$103
Physician and Other Practitioner	\$3,280,965	8,459	\$397	\$3,082,132	8,404	\$367
Prescription Drug	\$1,856,645	1,465	\$1,003	\$8,230	161	\$51
Public Health or Welfare	\$5,581	301	\$10	\$1,898	217	\$9
Public Health, Federal	\$79,540	226	\$477	\$14,445	211	\$68
Rural Health Clinic	\$95,093	1,033	\$97	\$87,413	1,026	\$85
Vision	\$82,651	1,527	\$58	\$57,362	1,295	\$44
Waiver - Total	\$113,896,507	3,837	\$29,684	--	--	--
Waiver-Community Choices	\$24,005,183	2,393	\$10,031	--	--	--
Waiver-Comprehensive	\$84,685,621	1,116	\$75,883	--	--	--
Waiver-Supports	\$5,205,703	328	\$15,871	--	--	--
Total	\$221,399,159	10,235	\$21,632	\$7,559,184	9,522	\$794

²³ Claims data for dual-enrolled members was included in the service area detail provided earlier in this report.

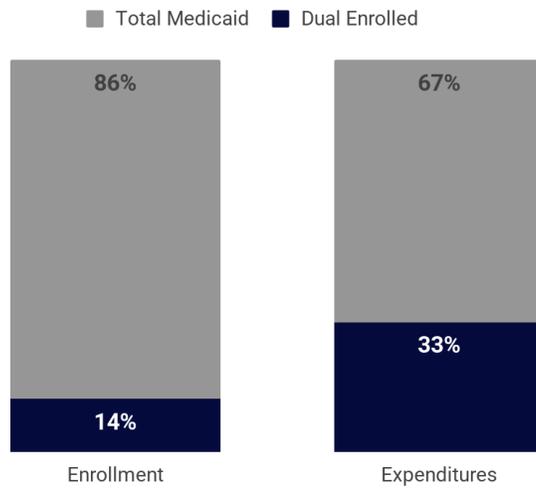


Figure 32. Dual Enrolled as Percent of Total Medicaid in SFY 2025

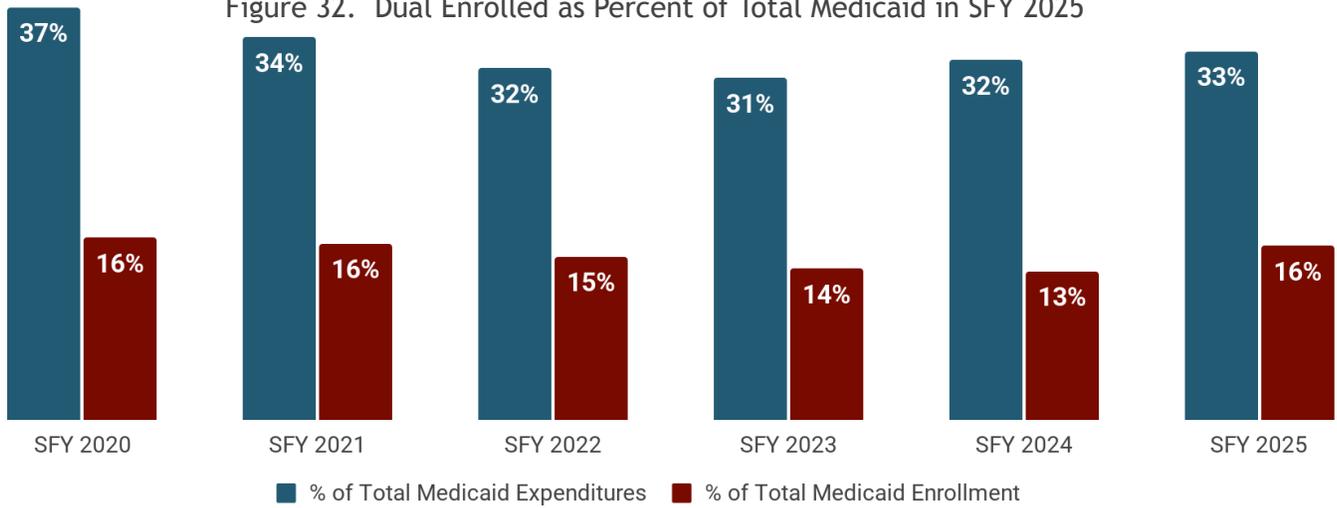


Figure 33. History of Dual Enrollment and Expenditures as Percent of Total Medicaid



Figure 34. History of Percentage of Crossover Claims of Total Dual Expenditures

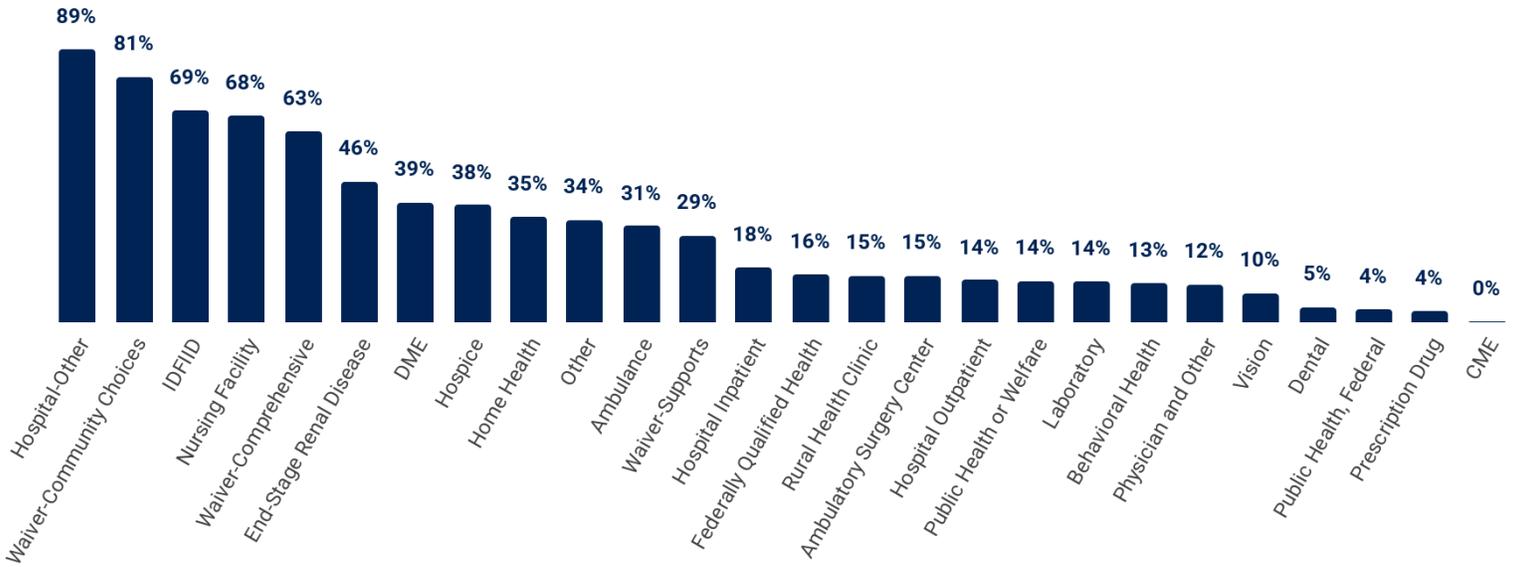


Figure 35. SFY 2025 Percent of Total Unduplicated Dual Recipients by Service

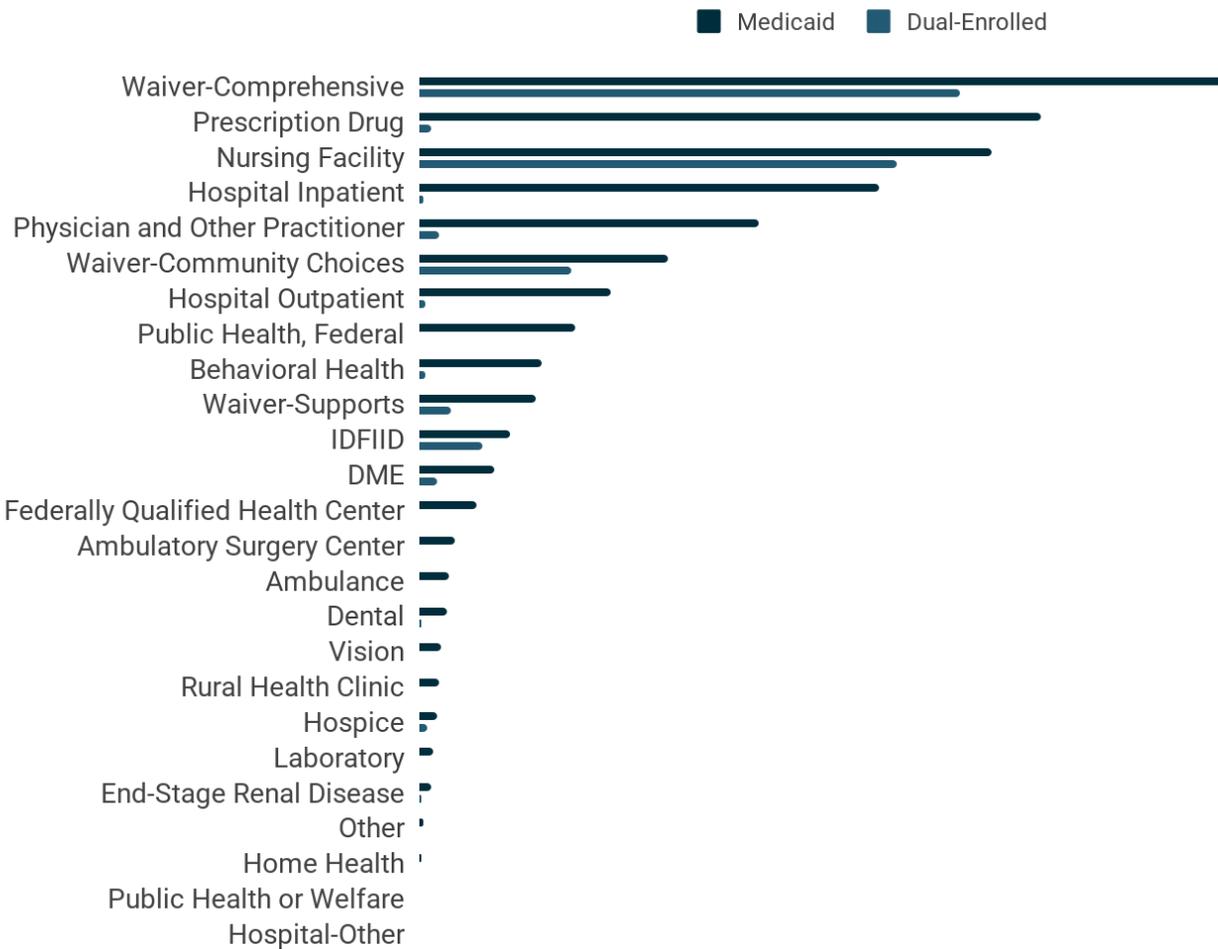


Figure 36. Dual Expenditures as Percent of Total Medicaid Expenditures by Service



Foster Care

The foster care program is administered through the Department of Family Services (DFS), providing for a child until a more permanent plan for the child's well-being can be implemented. Medical coverage under foster care is intended to provide for the medical needs of the children while in DFS custody. Two types of medical coverage are available:

Medicaid Foster Care

For children eligible for Medicaid. Foster children covered under Title IV-E of the Social Security Act and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid. Wyoming also uses existing Medicaid eligibility groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state-funded subsidies.

State Foster Care

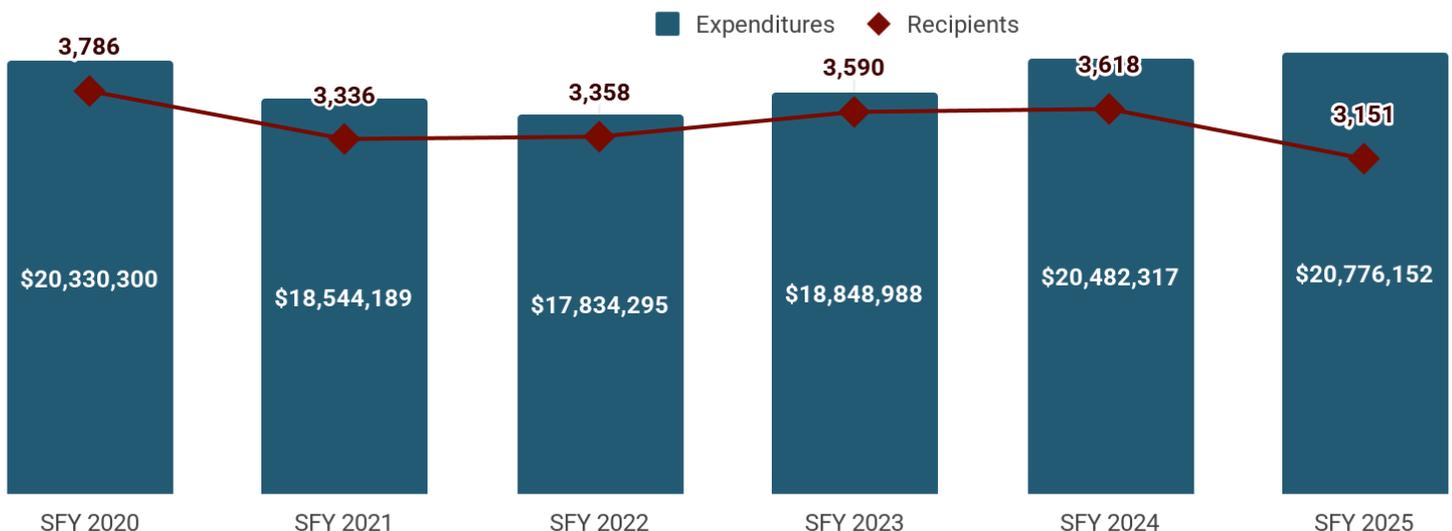
For children ineligible for Medicaid. Includes children who do not meet income or citizenship requirements or are institutionalized at the Boys' or Girls' School operated by the Department of Family Services.

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Children Enrolled

\$1,630,492

In Claim Expenditures



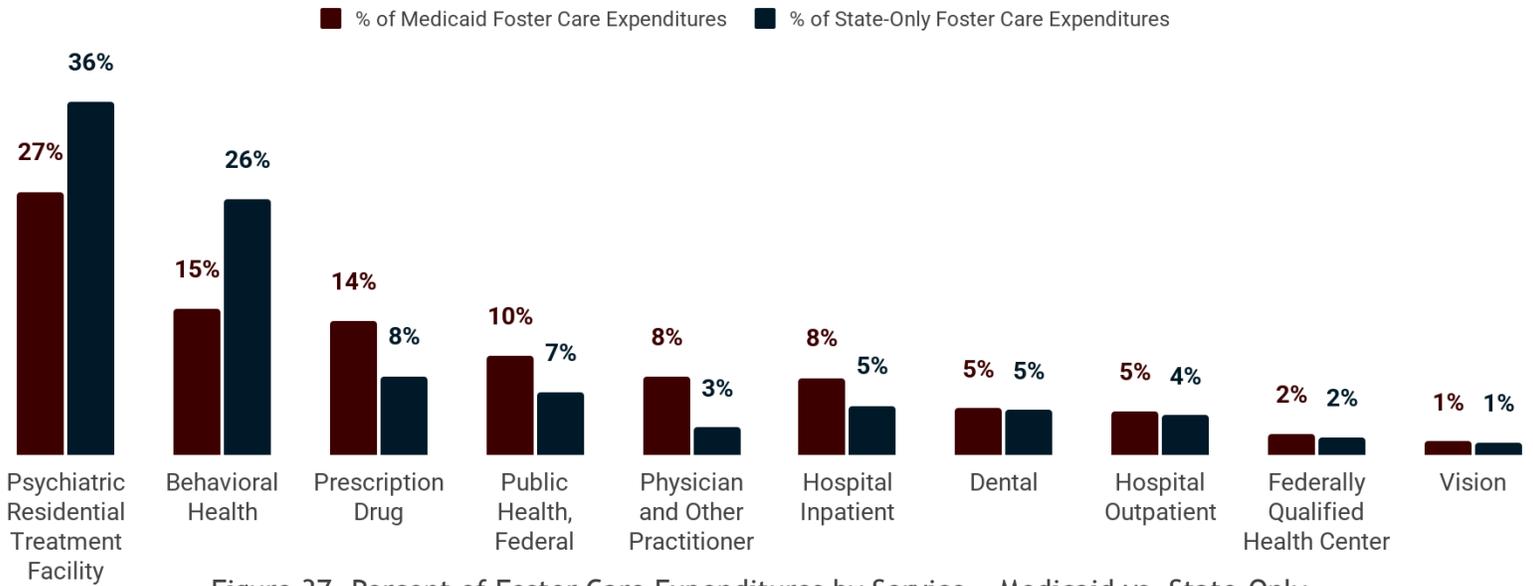


Figure 37. Percent of Foster Care Expenditures by Service - Medicaid vs. State-Only

Table 53. Foster Care Service Utilization History²⁴

Claim Paid Date SFY	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	5 Year % Change
Medicaid Foster Care							
Enrolled Members	2,932	2,918	3,395	3,732	3,845	3,345	14.1
Expenditures	\$19,115,700	\$17,599,763	\$16,902,823	\$17,826,034	\$19,169,652	\$19,145,660	0.2
Recipients	3,621	3,197	3,210	3,432	3,470	3,020	-16.6
Expenditures per Recipient	\$5,279	\$5,505	\$5,266	\$5,194	\$5,524	\$6,340	20.1
State-Only Foster Care							
Enrolled Members	155	159	195	242	244	237	52.9
Expenditures	\$1,214,600	\$944,427	\$931,472	\$1,022,954	\$1,312,665	\$1,630,492	34.2
Recipients	256	205	205	240	256	244	-4.7
Expenditures per Recipient	\$4,745	\$4,607	\$4,544	\$4,262	\$5,128	\$6,682	40.8

²⁴ As claims data shown is based on paid date, not service date, the number of recipients may exceed the count of enrolled members as individuals may have claims paid up to one year after services are rendered, at which time they may no longer be enrolled in the program.

Table 54. Foster Care Summary by Services - Medicaid vs. State-Only²⁵

Service Area	Medicaid Foster Care			State-Only Foster Care		
	Expenditures	Recipients	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	\$183,514	137	\$1,340	\$8,731	11	\$794
Ambulatory Surgery Center	\$206,253	90	\$2,292	--	--	--
Behavioral Health	\$2,878,659	1,310	\$2,197	\$429,222	185	\$2,320
Clinic/Center	\$88,936	118	\$754	--	--	--
Dental	\$921,599	1,642	\$561	\$75,856	109	\$696
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	\$150,736	153	\$985	\$9,006	< 10	--
Federally Qualified Health Center	\$432,811	354	\$1,223	\$30,158	41	\$736
Home Health	\$824	< 10	--	--	--	--
Hospice	\$0	< 10	--	--	--	--
Hospital Inpatient	\$1,529,286	167	\$9,157	\$84,084	11	\$7,644
Hospital Outpatient	\$867,764	1,170	\$742	\$67,512	85	\$794
Laboratory	\$53,701	181	\$297	\$1,914	< 10	--
Nursing Facility	\$0	< 10	--	--	--	--
Other	\$51,609	209	\$247	\$19,499	45	\$433
Physician and Other Practitioner	\$1,557,775	2,321	\$671	\$46,538	130	\$358
Prescription Drug	\$2,644,273	1,862	\$1,420	\$133,226	159	\$838
Psychiatric Residential Treatment Facility	\$5,188,502	77	\$67,383	\$592,224	13	\$45,556
Public Health or Welfare	\$8,650	75	\$115	\$784	20	\$39
Public Health, Federal	\$1,968,492	202	\$9,745	\$106,669	10	\$10,667
Rural Health Clinic	\$135,050	261	\$517	\$2,871	11	\$261
Vision	\$277,229	1,038	\$267	\$22,196	84	\$264
Total	\$19,145,660	3,020	\$6,340	\$1,630,492	244	\$6,682

²⁵ Values less than 10 are not shown in order to protect the privacy of recipients.

APPENDICES

APPENDIX A: SUPPLEMENTAL TABLES SERVICES

Provider	Services Provided
Outpatient Behavioral Health Providers	
<ul style="list-style-type: none"> Mental health and substance abuse treatment professionals through Community Mental Health Centers (CMHCs) and Substance Abuse Treatment Centers (SACs) 	<ul style="list-style-type: none"> Mental Health Assessments Individual Group Therapy Rehabilitation Services Peer Specialists Services Targeted-Case Management
<ul style="list-style-type: none"> Physicians, including psychiatrists, or other behavioral health practitioners who work under a physician, including: Physician Assistants 	<ul style="list-style-type: none"> Medically necessary psychiatric services
<ul style="list-style-type: none"> Advanced practice mental health nurse practitioners Independently practicing clinical psychologists Masters level counselors (e.g., Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs)) 	<ul style="list-style-type: none"> Behavioral Health Services
Inpatient Behavioral Health Providers	
<ul style="list-style-type: none"> Psychiatric Residential Treatment Facility 	<ul style="list-style-type: none"> Psychiatric residential treatment for individuals under age 21
<ul style="list-style-type: none"> Wyoming State Hospital 	<ul style="list-style-type: none"> Admits patients considered to be a danger to themselves or others pursuant to Wyoming Statue on involuntary hospitalization Patients who are psychiatrically and medically fragile Persons whom the legal system placed in the hospital after classifying them as not competent to stand trial or who were found guilty of committing crimes due to mental illness
<ul style="list-style-type: none"> Stand-Alone Inpatient Psychiatric Hospital 	<ul style="list-style-type: none"> Behavioral Health Services

Table 55. Waiver Services by Waiver

Waiver Services	Comprehensive	Supports	Community Choices	Children's Mental Health
Case Management	X	X	X	X
Functional Assessments	X	X	X	X
Respite	X	X	X	X
Personal Care	X	X	X	
Skilled Nursing	X	X	X	
Dietitian	X	X	X	
Homemaker	X	X	X	
Special Family Habilitation Home	X	X		
Day Habilitation	X	X		
Child Habilitation	X	X		
Residential Habilitation Training	X	X		
Specialized Equipment	X	X		
Environmental Modifications	X	X		
Supported Living	X	X		
Community Integrated Employment	X	X		
Employment Supports	X	X	X	
Companion	X	X		
Occupational, Physical, & Speech Therapies ²⁶	X	X		
Cognitive Retraining				
Self-Directed / Consumer-Directed Available ²⁷	X	X	X	
High Fidelity Wraparound				X
Family & Youth Peer Support Services				X

²⁶ These services are separate from and complementary to state plan Physical and Occupational Therapies.

²⁷ Self-Directed services are not a specific standalone service, but a different way other services can be managed.

BIRTHS

Table 56. Wyoming and Medicaid Births²⁸

Calendar Year	Wyoming Births	Medicaid Births	Medicaid % of Total
2014	7,679	2,857	37%
2015	7,724	2,784	36%
2016	7,386	2,918	40%
2017	6,904	2,683	39%
2018	6,563	2,526	38%
2019	6,568	2,423	37%
2020	6,132	2,258	37%
2021	6,238	2,210	35%
2022	6,050	2,108	35%
2023	5,993	2,082	35%
2024	6,085	2,131	35%

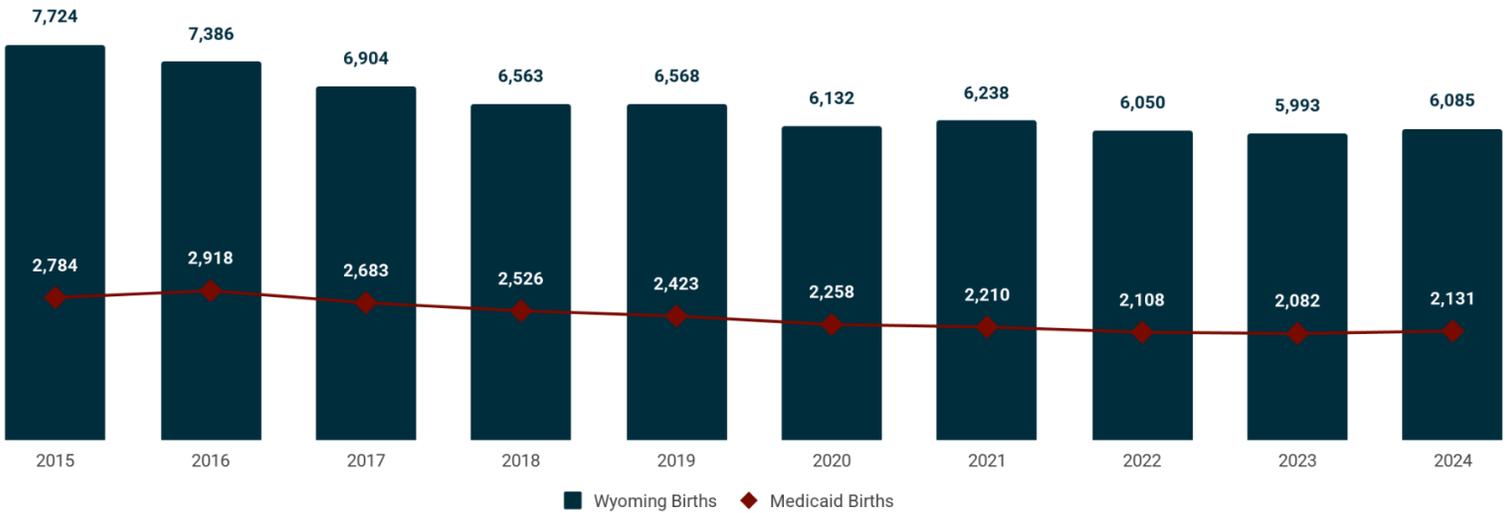


Figure 38. CY 2014 - 2024 Wyoming and Medicaid Births

²⁸ Provisional statistics for statewide births were supplied by Vital Records.

COUNTY DATA

Table 57. Medicaid County Summary

County	Enrolled Members ²⁹	% Of Total Enrolled Members	Recipients ³⁰	% Of Total Recipients	Expenditures	% Of Total Expenditures
Albany County	3,457	3.9%	3,060	4.1%	\$25,124,560	3.8%
Big Horn County	2,228	2.5%	1,970	2.6%	\$17,875,441	2.7%
Campbell County	7,198	8.1%	6,479	8.7%	\$39,645,720	5.9%
Carbon County	2,108	2.4%	1,755	2.4%	\$9,119,324	1.4%
Converse County	2,143	2.4%	1,969	2.6%	\$13,242,864	2.0%
Crook County	1,001	1.1%	928	1.2%	\$4,616,795	0.7%
Fremont County	9,384	10.5%	8,671	11.6%	\$129,498,189	19.4%
Goshen County	2,091	2.3%	1,741	2.3%	\$13,320,878	2.0%
Hot Springs County	869	1.0%	796	1.1%	\$7,240,854	1.1%
Johnson County	1,062	1.2%	910	1.2%	\$6,463,281	1.0%
Laramie County	14,106	15.8%	12,388	16.6%	\$103,546,206	15.5%
Lincoln County	1,974	2.2%	1,663	2.2%	\$13,085,827	2.0%
Natrona County	14,014	15.7%	12,925	17.4%	\$111,961,553	16.8%
Niobrara County	393	0.4%	316	0.4%	\$1,615,502	0.2%
Other ³¹	2,419	2.7%	956	1.3%	\$17,593,385	2.6%
Park County	3,743	4.2%	3,295	4.4%	\$23,934,346	3.6%
Platte County	1,263	1.4%	1,086	1.5%	\$7,631,005	1.1%
Sheridan County	4,115	4.6%	3,744	5.0%	\$30,427,016	4.6%
Sublette County	887	1.0%	673	0.9%	\$3,684,075	0.6%
Sweetwater County	6,393	7.2%	5,689	7.6%	\$39,786,374	6.0%
Teton County	1,116	1.3%	951	1.3%	\$5,702,581	0.9%
Uinta County	3,484	3.9%	3,136	4.2%	\$26,446,809	4.0%
Washakie County	1,271	1.4%	1,158	1.6%	\$9,747,045	1.5%
Weston County	989	1.1%	784	1.1%	\$5,869,553	0.9%
Overall	89,212		74,473		\$667,179,184	

²⁹ Enrollment is based on Complete SFY.

³⁰ Recipients and Expenditures are based on the recipient county of residence on file at the time the claim was processed in the MMIS. As recipients may move between counties, summing the county totals will not match the total recipient count shown.

³¹ Recipients in "Other" county have moved out of state prior to their claim being processed.

PROVIDERS

Table 58. SFY 2025 Provider Taxonomy Summary

Provider Taxonomy	Providers	Recipients	Expenditures
Advanced Practice Midwife (367A00000X)	2	42	\$39,251
Allergy & Immunology, Allergy (207KA0200X)	4	324	\$99,669
Ambulance (341600000X)	65	3,986	\$4,766,239
Anesthesiology (207L00000X)	46	6,746	\$2,309,923
Audiologist (231H00000X)	11	393	\$136,904
Behavior Analyst (103K00000X)	10	145	\$2,283,698
Case Management (251B00000X)	135	2,961	\$28,297,726
Chiropractor (111N00000X)	28	284	\$49,962
Clinic/Center (261Q00000X)	11	1,307	\$1,112,391
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	6	279	\$115,171
Clinic/Center, Ambulatory Surgical (261QA1903X)	35	3,554	\$5,851,382
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	14	119	\$1,930,967
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	21	8,370	\$9,259,051
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	37	2,878	\$2,041,342
Clinic/Center, Public Health, Federal (261QP0904X)	6	3,859	\$24,636,454
Clinic/Center, Recovery Care (261QR0800X)	30	562	\$288,373
Clinic/Center, Rehabilitation (261QR0400X)	1	1	\$142
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	60	\$26,110
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	31	2,213	\$2,195,128
Clinic/Center, Rural Health (261QR1300X)	35	6,699	\$3,343,108
Clinical Medical Laboratory (291U00000X)	79	7,033	\$2,315,934
Clinical Neuropsychologist (103G00000X)	1	39	\$16,280
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	20	1,133	\$410,822
Community Based Residential Treatment Facility, Mental Illness (320800000X)	3	4	\$0
Community/Behavioral Health (251S00000X)	27	570	\$4,474,014
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	3	25	\$17,375
Counselor, Professional (101YP2500X)	180	4,436	\$5,970,983
Day Training, Developmentally Disabled Services (251C00000X)	583	3,341	\$134,191,574
Dentist (122300000X)	37	4,228	\$1,889,597
Dentist, Endodontics (1223E0200X)	2	29	\$26,413
Dentist, General Practice (1223G0001X)	88	10,995	\$4,847,388

Table 58. SFY 2025 Provider Taxonomy Summary (cont.)

Provider Taxonomy	Providers	Recipients	Expenditures
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	8	395	\$427,504
Dentist, Pediatric Dentistry (1223P0221X)	33	15,503	\$7,371,647
Dermatology (207N00000X)	15	2,380	\$345,625
Dietitian, Registered (133V00000X)	3	51	\$10,245
Durable Medical Equipment & Medical Supplies (332B00000X)	225	8,185	\$10,828,831
Emergency Medicine (207P00000X)	35	20,157	\$4,819,683
Family Medicine (207Q00000X)	84	21,905	\$5,535,276
General Acute Care Hospital (282N00000X)	116	31,772	\$87,778,695
General Acute Care Hospital, Rural (282NR1301X)	28	10,405	\$13,749,622
Hearing Aid Equipment (332S00000X)	2	96	\$246,838
Home Health (251E00000X)	24	314	\$519,329
Hospice Care, Community Based (251G00000X)	13	268	\$2,797,333
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	35	\$14,256,180
Internal Medicine (207R00000X)	59	16,396	\$7,346,791
Internal Medicine, Cardiovascular Disease (207RC0000X)	14	2,394	\$450,791
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	3	34	\$6,295
Internal Medicine, Gastroenterology (207RG0100X)	8	1,622	\$410,848
Internal Medicine, Geriatric Medicine (207RG0300X)	5	489	\$106,248
Internal Medicine, Medical Oncology (207RX0202X)	4	245	\$1,153,649
Internal Medicine, Nephrology (207RN0300X)	7	444	\$64,457
Internal Medicine, Pulmonary Disease (207RP1001X)	5	349	\$71,030
Internal Medicine, Rheumatology (207RR0500X)	2	148	\$13,084
Interpreter (171R00000X)	2	7	\$3,745
Lodging (177F00000X)	3	260	\$159,260
Marriage & Family Therapist (106H00000X)	16	361	\$713,854
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	25	\$5,138
Medicare Defined Swing Bed Unit (275N00000X)	13	64	\$1,274,785
Midwife (176B00000X)	4	33	\$34,599
Neurological Surgery (207T00000X)	9	451	\$1,460,611
Nurse Anesthetist, Certified Registered (367500000X)	14	618	\$103,952
Nurse Practitioner (363L00000X)	30	2,054	\$507,191
Nurse Practitioner, Adult Health (363LA2200X)	2	125	\$181,961
Nurse Practitioner, Family (363LF0000X)	26	2,303	\$436,902
Nurse Practitioner, Pediatrics (363LP0200X)	3	433	\$149,861
Obstetrics & Gynecology (207V00000X)	31	3,979	\$3,367,757

Table 58. SFY 2025 Provider Taxonomy Summary (cont.)

Provider Taxonomy	Providers	Recipients	Expenditures
Obstetrics & Gynecology, Gynecology (207VG0400X)	2	93	\$15,157
Obstetrics & Gynecology, Obstetrics (207VX0000X)	3	20	\$14,424
Occupational Therapist (225X00000X)	18	766	\$1,894,853
Ophthalmology (207W00000X)	26	1,419	\$496,419
Optometrist (152W00000X)	74	14,582	\$3,602,988
Orthopedic Surgery (207X00000X)	27	4,218	\$1,408,531
Otolaryngology (207Y00000X)	12	2,532	\$796,606
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	15	1,990	\$117,448
Pediatrics (208000000X)	75	11,510	\$4,036,058
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	7	585	\$323,001
Pharmacy (333600000X)	222	40,244	\$97,540,034
Pharmacy, Community/Retail Pharmacy (3336C0003X)	10	126	\$9,784
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	1	3	\$1,114
Pharmacy, Long Term Care Pharmacy (3336L0003X)	1	30	\$22
Physical Medicine & Rehabilitation (208100000X)	14	246	\$167,821
Physical Therapist (225100000X)	83	4,289	\$4,569,180
Physician Assistant (363A00000X)	2	53	\$12,875
Physician, General Practice (208D00000X)	66	17,511	\$6,401,006
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	4	38	\$28,734
Podiatrist (213E00000X)	11	1,064	\$91,046
Private Vehicle (347C00000X)	1	21	\$4,179
Prosthetic/Orthotic Supplier (335E00000X)	27	882	\$741,680
Psychiatric Hospital (283Q00000X)	3	20	\$85,856
Psychiatric Residential Treatment Facility (323P00000X)	13	198	\$12,848,262
Psychiatry & Neurology, Neurology (2084N0400X)	26	1,435	\$376,449
Psychiatry & Neurology, Psychiatry (2084P0800X)	23	1,043	\$1,318,703
Psychologist, Clinical (103TC0700X)	36	1,620	\$1,775,035
Public Health or Welfare (251K00000X)	23	2,197	\$271,422
Radiology, Diagnostic Radiology (2085R0202X)	44	17,507	\$1,940,233
Rehabilitation Hospital (283X00000X)	4	86	\$594,176
Skilled Nursing Facility (314000000X)	46	1,870	\$88,394,604
Social Worker, Clinical (1041C0700X)	116	2,347	\$2,671,280
Specialist (174400000X)	2	586	\$90,129
Speech-Language Pathologist (235Z00000X)	17	475	\$662,932
Substance Abuse Rehabilitation Facility (324500000X)	1	28	\$1,349
Supports Brokerage (251X00000X)	2	1,267	\$21,858,685

Table 58. SFY 2025 Provider Taxonomy Summary (cont.)

Provider Taxonomy	Providers	Recipients ³²	Expenditures
Surgery (208600000X)	29	1,163	\$409,953
Surgery, Pediatric Surgery (2086S0120X)	4	67	\$48,938
Surgery, Vascular Surgery (2086S0129X)	5	43	\$16,622
Technician/Technologist, Optician (156FX1800X)	3	75	\$9,595
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	2	17	\$12,385
Urology (208800000X)	9	1,144	\$301,701
Total	3,519	74,473	\$667,179,184

Table 59. SFY 2025 Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Services (251C00000X)	\$134,191,574	20%
Pharmacy (333600000X)	\$97,540,034	14%
Skilled Nursing Facility (314000000X)	\$88,394,604	13%
General Acute Care Hospital (282N00000X)	\$87,778,695	13%
Case Management (251B00000X)	\$28,297,726	4%
Clinic/Center, Public Health, Federal (261QP0904X)	\$24,636,454	4%
Supports Brokerage (251X00000X)	\$21,858,685	3%
Intermediate Care Facility, Intellectually Disabled (315P00000X)	\$14,256,180	2%
General Acute Care Hospital, Rural (282NR1301X)	\$13,749,622	2%
Psychiatric Residential Treatment Facility (323P00000X)	\$12,848,262	2%
Durable Medical Equipment & Medical Supplies (332B00000X)	\$10,828,831	2%
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	\$9,259,051	1%
Dentist, Pediatric Dentistry (1223P0221X)	\$7,371,647	1%
Internal Medicine (207R00000X)	\$7,346,791	1%
Physician, General Practice (208D00000X)	\$6,401,006	1%
Counselor, Professional (101YP2500X)	\$5,970,983	1%
Clinic/Center, Ambulatory Surgical (261QA1903X)	\$5,851,382	1%
Family Medicine (207Q00000X)	\$5,535,276	1%
Dentist, General Practice (1223G0001X)	\$4,847,388	1%
Emergency Medicine (207P00000X)	\$4,819,683	1%

³² This table displays a unique count of recipients for each provider taxonomy. Summing the recipients across all taxonomies will not equal the total recipients shown as recipients often receive multiple services throughout the SFY.

Table 60. Pay-to-Provider Count History by Taxonomy

Pay To Provider ID	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Advanced Practice Midwife (367A00000X)	4	3	3	3	2	2
Allergy & Immunology, Allergy (207KA0200X)	5	6	7	6	6	4
Ambulance (341600000X)	66	67	72	67	67	65
Anesthesiology (207L00000X)	56	56	55	51	46	46
Audiologist (231H00000X)	12	13	13	12	10	11
Behavior Analyst (103K00000X)	7	5	6	8	9	10
Case Management (251B00000X)	128	129	129	124	123	135
Chiropractor (111N00000X)	54	55	37	30	25	28
Clinic/Center (261Q00000X)	12	11	10	11	11	11
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	5	5	5	6	6	6
Clinic/Center, Ambulatory Surgical (261QA1903X)	27	30	31	37	36	35
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	15	15	15	15	16	14
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	16	15	16	23	21	21
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	27	27	32	33	29	37
Clinic/Center, Public Health, Federal (261QP0904X)	4	5	4	4	5	6
Clinic/Center, Radiology, Mobile (261QR0208X)	1	--	1	1	1	--
Clinic/Center, Recovery Care (261QR0800X)	--	--	--	--	--	30
Clinic/Center, Rehabilitation (261QR0400X)	--	--	--	--	--	1
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	33	32	36	41	34	31
Clinic/Center, Rural Health (261QR1300X)	31	34	31	31	35	35
Clinical Medical Laboratory (291U00000X)	70	76	83	88	78	79
Clinical Neuropsychologist (103G00000X)	5	1	1			1
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	10	10	12	15	16	20
Community Based Residential Treatment Facility, Mental Illness (320800000X)	--	--	--	--	--	3

Table 60. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Community/Behavioral Health (251S00000X)	1	29	40	39	33	27
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	3	4	2	4	2	3
Counselor, Professional (101YP2500X)	155	154	164	171	170	180
Day Training, Developmentally Disabled Services (251C00000X)	659	623	605	566	556	583
Dentist (122300000X)	31	31	29	30	32	37
Dentist, Endodontics (1223E0200X)	4	3	3	3	3	2
Dentist, General Practice (1223G0001X)	121	109	110	104	99	88
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	11	9	9	12	10	10
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	14	14	13	10	10	8
Dentist, Pediatric Dentistry (1223P0221X)	33	30	33	33	35	33
Dermatology (207N00000X)	16	16	16	15	14	15
Dietitian, Registered (133V00000X)	2	2	2	3	3	3
Durable Medical Equipment & Medical Supplies (332B00000X)	202	204	215	219	224	225
Emergency Medical Technician, Basic (146N00000X)	--	--	1	--	--	--
Emergency Medicine (207P00000X)	29	32	31	30	35	35
Family Medicine (207Q00000X)	86	80	83	85	83	84
General Acute Care Hospital (282N00000X)	103	108	117	126	142	116
General Acute Care Hospital, Rural (282NR1301X)	26	32	32	40	35	28
Hearing Aid Equipment (332S00000X)	9	9	6	2	1	2
Home Health (251E00000X)	23	20	23	24	29	24
Hospice Care, Community Based (251G00000X)	13	14	14	15	16	13
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	1	1	1	1	1
Internal Medicine (207R00000X)	57	59	57	62	61	59
Internal Medicine, Cardiovascular Disease (207RC0000X)	20	17	16	14	14	14
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	4	3	4	4	4	3
Internal Medicine, Gastroenterology (207RG0100X)	6	7	7	7	9	8

Table 60. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Internal Medicine, Geriatric Medicine (207RG0300X)	5	4	6	6	4	5
Internal Medicine, Medical Oncology (207RX0202X)	4	4	6	6	5	4
Internal Medicine, Nephrology (207RN0300X)	6	6	6	8	6	7
Internal Medicine, Pulmonary Disease (207RP1001X)	8	8	7	7	7	5
Internal Medicine, Rheumatology (207RR0500X)	2	3	2	2	2	2
Interpreter (171R00000X)	2	2	2	3	4	2
Local Education Agency (LEA) (251300000X)	--	--	--	1	1	--
Lodging (177F00000X)	2	4	4	4	3	3
Marriage & Family Therapist (106H00000X)	10	12	15	15	16	16
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	1	1	1	1	1
Medicare Defined Swing Bed Unit (275N00000X)	12	13	13	12	14	13
Midwife (176B00000X)	3	3	5	5	4	4
Neurological Surgery (207T00000X)	9	11	10	9	9	9
Nurse Anesthetist, Certified Registered (367500000X)	13	12	14	15	14	14
Nurse Practitioner (363L00000X)	14	17	14	18	22	30
Nurse Practitioner, Adult Health (363LA2200X)	1	1	1	2	2	2
Nurse Practitioner, Family (363LF0000X)	23	23	18	22	26	26
Nurse Practitioner, Pediatrics (363LP0200X)	3	3	3	3	2	3
Obstetrics & Gynecology (207V00000X)	27	27	28	28	30	31
Obstetrics & Gynecology, Gynecology (207VG0400X)	4	2	2	2	2	2
Obstetrics & Gynecology, Obstetrics (207VX0000X)	4	4	3	3	3	3
Occupational Therapist (225X00000X)	14	14	14	17	16	18
Ophthalmology (207W00000X)	32	35	31	30	26	26
Optometrist (152W00000X)	77	83	81	77	78	74
Orthopedic Surgery (207X00000X)	30	29	27	25	26	27
Otolaryngology (207Y00000X)	15	15	13	16	13	12

Table 60. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	14	13	13	12	14	15
Pediatrics (208000000X)	69	65	63	73	76	75
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	4	5	4	7	8	7
Pharmacy (333600000X)	205	215	218	211	210	222
Pharmacy, Community/Retail Pharmacy (3336C0003X)	--	--	--	4	3	10
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	1	2	1	1
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	1	1	1	1
Physical Medicine & Rehabilitation (208100000X)	14	12	14	15	16	14
Physical Therapist (225100000X)	66	75	80	84	89	83
Physician Assistant (363A00000X)	5	2	3	2	2	2
Physician, General Practice (208D00000X)	61	58	60	68	67	66
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	8	5	4	4	2	4
Podiatrist (213E00000X)	14	12	13	11	11	11
Preventive Medicine, Public Health & General Preventive Medicine (2083P0901X)	--	--	--	1	--	--
Private Vehicle (347C00000X)	3	2	1	2	1	1
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	1	1	--	--	--	--
Prosthetic/Orthotic Supplier (335E00000X)	28	27	29	29	28	27
Psychiatric Hospital (283Q00000X)	4	3	3	6	4	3
Psychiatric Residential Treatment Facility (323P00000X)	13	14	6	8	9	13
Psychiatry & Neurology, Neurology (2084N0400X)	21	19	18	20	19	26
Psychiatry & Neurology, Psychiatry (2084P0800X)	21	20	20	21	22	23
Psychologist, Clinical (103TC0700X)	59	53	49	48	41	36
Public Health or Welfare (251K00000X)	24	25	25	22	22	23
Radiology, Diagnostic Radiology (2085R0202X)	44	41	38	46	48	44
Rehabilitation Hospital (283X00000X)	2	3	3	2	5	4

Table 60. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Rehabilitation Hospital (283X00000X)	2	3	3	2	5	4
Skilled Nursing Facility (314000000X)	56	48	48	47	49	46
Social Worker, Clinical (1041C0700X)	94	96	110	110	108	116
Specialist (174400000X)	4	3	2	2	2	2
Speech-Language Pathologist (235Z00000X)	10	13	14	14	16	17
Substance Abuse Rehabilitation Facility (324500000X)	--	--	--	--	--	1
Supports Brokerage (251X00000X)	1	1	1	2	2	2
Surgery (208600000X)	31	32	26	26	27	29
Surgery, Pediatric Surgery (2086S0120X)	5	5	4	4	4	4
Surgery, Vascular Surgery (2086S0129X)	4	4	5	5	5	5
Taxi (344600000X)	1	2	1	--	--	--
Technician/Technologist, Optician (156FX1800X)	6	5	6	6	6	3
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	2	1	1	2	1	2
Unclassified	1	1	--	--	--	--
Urology (208800000X)	12	10	11	11	11	9
Urology (208800000X)	12	10	11	11	11	9
Urology (208800000X)	12	10	11	11	11	9

Table 61. Pay-to-Provider Expenditure History by Taxonomy

Pay-To-Provider Taxonomy	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Advanced Practice Midwife (367A00000X)	\$27,464	\$16,866	\$30,193	\$40,106	\$54,926	\$39,251
Allergy & Immunology, Allergy (207KA0200X)	\$210,462	\$126,285	\$141,790	\$144,159	\$137,741	\$99,669
Ambulance (341600000X)	\$2,869,734	\$3,452,295	\$3,274,007	\$4,579,196	\$5,062,622	\$4,766,239
Anesthesiology (207L00000X)	\$2,387,211	\$2,402,861	\$2,460,240	\$2,269,071	\$2,276,500	\$2,309,923
Audiologist (231H00000X)	\$344,821	\$176,061	\$166,964	\$260,255	\$171,471	\$136,904
Behavior Analyst (103K00000X)	\$831,883	\$1,673,558	\$1,597,739	\$605,070	\$1,048,366	\$2,283,698
Case Management (251B00000X)	\$29,686,195	\$33,151,973	\$33,421,019	\$32,473,528	\$28,196,671	\$28,297,726
Chiropractor (111N00000X)	\$368,608	\$343,860	\$22,007	\$56,585	\$61,544	\$49,962
Clinic/Center (261Q00000X)	\$435,776	\$720,828	\$819,588	\$1,074,939	\$1,037,884	\$1,112,391
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	\$48,668	\$44,687	\$67,307	\$71,788	\$109,241	\$115,171
Clinic/Center, Ambulatory Surgical (261QA1903X)	\$3,170,249	\$4,294,509	\$5,292,824	\$6,737,900	\$6,547,398	\$5,851,382
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	\$1,595,216	\$2,172,271	\$2,249,469	\$1,974,983	\$1,597,664	\$1,930,967
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	\$6,554,011	\$6,954,823	\$9,022,975	\$9,937,270	\$10,655,469	\$9,259,051
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	\$3,951,005	\$2,998,132	\$2,894,688	\$3,150,732	\$2,428,900	\$2,041,342
Clinic/Center, Public Health, Federal (261QP0904X)	\$11,864,895	\$17,744,075	\$21,925,627	\$24,015,386	\$29,847,495	\$24,636,454
Clinic/Center, Radiology, Mobile (261QR0208X)	--	--	\$158	\$164	--	--
Clinic/Center, Recovery Care (261QR0800X)	--	--	--	--	--	\$288,373
Clinic/Center, Rehabilitation (261QR0400X)	--	--	--	--	--	\$142
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	\$22,394	\$28,662	\$34,668	\$24,867	\$42,095	\$26,110
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	\$3,065,233	\$2,268,259	\$2,003,447	\$2,244,489	\$2,522,678	\$2,195,128
Clinic/Center, Rural Health (261QR1300X)	\$2,377,607	\$2,776,034	\$3,647,268	\$3,449,338	\$4,473,408	\$3,343,108
Clinical Medical Laboratory (291U00000X)	\$585,977	\$810,495	\$1,078,644	\$1,817,952	\$1,970,386	\$2,315,934
Clinical Neuropsychologist (103G00000X)	\$37,580	\$23,900	\$23	--	--	\$16,280
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	\$278,963	\$277,798	\$207,439	\$262,784	\$408,428	\$410,822

Table 61. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Community Based Residential Treatment Facility, Mental Illness (320800000X)	--	--	--	--	--	--
Community/Behavioral Health (251S00000X)	\$3,928,461	\$3,083,633	\$3,245,019	\$3,943,909	\$3,135,717	\$4,474,014
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	\$62,187	\$15,045	\$3,223	\$14,498	\$12,517	\$17,375
Counselor, Professional (101YP2500X)	\$4,184,775	\$4,762,208	\$4,292,523	\$5,061,940	\$5,489,566	\$5,970,983
Day Training, Developmentally Disabled Services (251C00000X)	\$114,398,383	\$115,427,114	\$109,625,371	\$119,599,245	\$128,768,958	\$134,191,574
Dentist (122300000X)	\$867,521	\$1,366,618	\$1,316,876	\$1,409,479	\$1,867,693	\$1,889,597
Dentist, Endodontics (1223E0200X)	\$52,182	\$69,098	\$73,178	\$87,025	\$54,714	\$26,413
Dentist, General Practice (1223G0001X)	\$3,089,844	\$3,769,032	\$3,726,737	\$4,429,335	\$4,574,239	\$4,847,388
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	\$873,145	\$1,195,512	\$1,297,572	\$1,294,614	\$1,606,228	\$1,564,932
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	\$261,832	\$294,792	\$368,657	\$329,983	\$367,382	\$427,504
Dentist, Pediatric Dentistry (1223P0221X)	\$4,749,104	\$5,803,729	\$6,017,041	\$6,729,118	\$7,578,528	\$7,371,647
Dermatology (207N00000X)	\$254,356	\$301,765	\$337,052	\$416,717	\$448,511	\$345,625
Dietitian, Registered (133V00000X)	\$697	\$385	\$2,647	\$4,062	\$5,337	\$10,245
Durable Medical Equipment & Medical Supplies (332B00000X)	\$8,174,435	\$8,783,787	\$9,254,405	\$11,019,987	\$11,325,201	\$10,828,831
Emergency Medical Technician, Basic (146N00000X)	--	--	\$46	--	--	--
Emergency Medicine (207P00000X)	\$3,400,286	\$3,502,145	\$4,426,478	\$4,933,542	\$5,079,169	\$4,819,683
Family Medicine (207Q00000X)	\$5,163,045	\$4,800,003	\$4,811,423	\$6,060,799	\$6,429,657	\$5,535,276
General Acute Care Hospital (282N00000X)	\$75,855,320	\$85,729,887	\$91,841,923	\$99,677,358	\$95,377,887	\$87,778,695
General Acute Care Hospital, Rural (282NR1301X)	\$11,589,064	\$11,672,738	\$13,149,379	\$16,866,583	\$14,997,405	\$13,749,622
Hearing Aid Equipment (332S00000X)	\$775,873	\$499,189	\$164,389	\$127,341	\$105,956	\$246,838
Home Health (251E00000X)	\$1,004,397	\$994,656	\$990,420	\$515,033	\$564,449	\$519,329
Hospice Care, Community Based (251G00000X)	\$1,251,068	\$1,306,111	\$921,529	\$1,442,367	\$2,151,504	\$2,797,333
Intermediate Care Facility, Intellectually Disabled (315P00000X)	\$16,058,915	\$17,024,561	\$16,842,461	\$18,318,585	\$16,366,887	\$14,256,180
Internal Medicine (207R00000X)	\$6,517,068	\$7,098,299	\$7,281,881	\$8,039,515	\$7,615,972	\$7,346,791
Internal Medicine, Cardiovascular Disease (207RC0000X)	\$326,970	\$355,553	\$406,376	\$478,654	\$477,772	\$450,791
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	\$23,002	\$20,706	\$21,034	\$19,134	\$15,402	\$6,295

Table 61. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Internal Medicine, Gastroenterology (207RG0100X)	\$423,968	\$741,026	\$726,845	\$722,332	\$636,120	\$410,848
Internal Medicine, Geriatric Medicine (207RG0300X)	\$43,886	\$42,598	\$62,352	\$89,000	\$101,690	\$106,248
Internal Medicine, Medical Oncology (207RX0202X)	\$2,155,922	\$647,946	-\$1,573	\$2,402	-\$5,791	\$1,153,649
Internal Medicine, Nephrology (207RN0300X)	\$73,053	\$62,204	\$94,006	\$77,501	\$59,506	\$64,457
Internal Medicine, Pulmonary Disease (207RP1001X)	\$91,720	\$114,401	\$125,623	\$137,298	\$104,186	\$71,030
Internal Medicine, Rheumatology (207RR0500X)	\$8,389	\$18,004	\$17,537	\$19,945	\$19,533	\$13,084
Interpreter (171R00000X)	\$9,096	\$19,514	\$21,284	\$21,846	\$1,623	\$3,745
Local Education Agency (LEA) (251300000X)	--	--	--	\$40,310	\$20,788	--
Lodging (177F00000X)	\$108,735	\$105,760	\$151,589	\$170,522	\$198,146	\$159,260
Marriage & Family Therapist (106H00000X)	\$376,927	\$519,535	\$560,234	\$533,288	\$491,319	\$713,854
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	\$3,083	\$4,610	\$5,141	\$3,890	\$6,283	\$5,138
Medicare Defined Swing Bed Unit (275N00000X)	\$557,037	\$633,663	\$287,091	\$959,118	\$931,680	\$1,274,785
Midwife (176B00000X)	\$14,782	\$36,514	\$44,161	\$32,686	\$30,377	\$34,599
Neurological Surgery (207T00000X)	\$88,516	\$3,913,244	\$2,464,651	\$2,915,224	\$2,403,059	\$1,460,611
Nurse Anesthetist, Certified Registered (367500000X)	\$86,639	\$136,749	\$149,739	\$126,512	\$124,704	\$103,952
Nurse Practitioner (363L00000X)	\$277,571	\$340,401	\$523,985	\$647,628	\$444,246	\$507,191
Nurse Practitioner, Adult Health (363LA2200X)	\$2,958	\$1,973	\$1,146	\$35,680	\$143,821	\$181,961
Nurse Practitioner, Family (363LF0000X)	\$338,367	\$371,188	\$460,522	\$530,811	\$453,114	\$436,902
Nurse Practitioner, Pediatrics (363LP0200X)	\$16,328	\$20,493	\$53,009	\$53,301	\$24,836	\$149,861
Obstetrics & Gynecology (207V00000X)	\$3,657,589	\$3,731,175	\$4,023,250	\$4,217,686	\$4,087,196	\$3,367,757
Obstetrics & Gynecology, Gynecology (207VG0400X)	\$94,634	\$99,103	\$95,881	\$85,228	\$36,452	\$15,157
Obstetrics & Gynecology, Obstetrics (207VX0000X)	\$474,269	\$253,841	\$998	\$53,591	\$16,946	\$14,424
Occupational Therapist (225X00000X)	\$1,630,049	\$1,623,882	\$1,387,546	\$1,449,895	\$1,659,457	\$1,894,853
Ophthalmology (207W00000X)	\$542,002	\$664,898	\$651,842	\$644,860	\$482,121	\$496,419
Optometrist (152W00000X)	\$2,930,037	\$3,675,630	\$3,594,187	\$3,853,367	\$3,680,502	\$3,602,988
Orthopedic Surgery (207X00000X)	\$1,344,579	\$1,434,339	\$1,702,363	\$1,690,165	\$1,547,623	\$1,408,531

Table 61. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Otolaryngology (207Y00000X)	\$523,531	\$726,418	\$814,430	\$829,657	\$875,317	\$796,606
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	\$80,615	\$68,216	\$276,534	\$333,253	\$211,313	\$117,448
Pediatrics (208000000X)	\$3,931,424	\$4,533,536	\$4,707,928	\$5,024,836	\$4,416,080	\$4,036,058
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	\$283,124	\$333,584	\$319,887	\$290,420	\$460,736	\$323,001
Pharmacy (333600000X)	\$60,432,330	\$67,781,176	\$84,438,042	\$98,128,284	\$97,610,755	\$97,540,034
Pharmacy, Community/Retail Pharmacy (3336C0003X)	--	--	--	\$26,952	\$12,448	\$9,784
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	\$233	\$263	\$1,142	\$1,114
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	\$2	--	--	\$22
Physical Medicine & Rehabilitation (208100000X)	\$123,650	\$157,851	\$145,182	\$250,182	\$201,559	\$167,821
Physical Therapist (225100000X)	\$2,316,327	\$3,100,810	\$3,689,457	\$3,882,805	\$4,284,931	\$4,569,180
Physician Assistant (363A00000X)	\$26,466	\$38,811	\$44,103	\$20,347	\$18,360	\$12,875
Physician, General Practice (208D00000X)	\$7,102,898	\$7,106,319	\$7,507,309	\$8,973,306	\$8,313,278	\$6,401,006
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	\$16,093	\$9,524	\$16,575	\$15,619	\$18,975	\$28,734
Podiatrist (213E00000X)	\$42,304	\$34,640	\$32,484	\$39,972	\$84,390	\$91,046
Preventive Medicine, Public Health & General Preventive Medicine (2083P0901X)	--	--	--	\$69	--	--
Private Vehicle (347C00000X)	\$12,973	\$8,702	\$5,949	\$7,696	\$5,808	\$4,179
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	\$3,586,650	\$2,152,985	--	--	--	--
Prosthetic/Orthotic Supplier (335E00000X)	\$540,444	\$614,067	\$584,124	\$617,354	\$643,326	\$741,680
Psychiatric Hospital (283Q00000X)	\$21,285	\$75,743	\$101,841	\$255,834	\$54,291	\$85,856
Psychiatric Residential Treatment Facility (323P00000X)	\$7,334,441	\$7,577,518	\$6,127,480	\$6,685,351	\$11,522,485	\$12,848,262
Psychiatry & Neurology, Neurology (2084N0400X)	\$333,100	\$329,532	\$327,801	\$484,029	\$334,873	\$376,449
Psychiatry & Neurology, Psychiatry (2084P0800X)	\$1,570,802	\$1,893,488	\$1,327,071	\$1,307,887	\$1,385,644	\$1,318,703
Psychologist, Clinical (103TC0700X)	\$4,887,558	\$3,668,549	\$2,472,285	\$2,333,625	\$1,906,104	\$1,775,035
Public Health or Welfare (251K00000X)	\$898,521	\$698,200	\$366,426	\$231,791	\$170,983	\$271,422

Table 61. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Radiology, Diagnostic Radiology (2085R0202X)	\$1,538,606	\$1,889,630	\$3,352,644	\$4,730,533	\$3,798,932	\$1,940,233
Rehabilitation Hospital (283X00000X)	\$408,441	\$567,445	\$546,854	\$711,661	\$288,297	\$594,176
Skilled Nursing Facility (314000000X)	\$88,869,925	\$77,813,463	\$72,353,230	\$78,344,782	\$93,444,243	\$88,394,604
Social Worker, Clinical (1041C0700X)	\$2,944,198	\$2,750,770	\$2,807,472	\$3,265,545	\$2,884,841	\$2,671,280
Specialist (174400000X)	\$60,043	\$57,929	\$48,087	\$67,950	\$63,395	\$90,129
Speech-Language Pathologist (235Z00000X)	\$411,291	\$376,895	\$408,640	\$483,875	\$532,960	\$662,932
Substance Abuse Rehabilitation Facility (324500000X)	--	--	--	--	--	\$1,349
Supports Brokerage (251X00000X)	\$6,172,411	\$6,977,663	\$7,139,257	\$13,184,427	\$19,618,667	\$21,858,685
Surgery (208600000X)	\$502,970	\$593,464	\$554,557	\$644,695	\$510,747	\$409,953
Surgery, Pediatric Surgery (2086S0120X)	\$33,952	\$51,964	\$27,761	\$52,504	\$42,926	\$48,938
Surgery, Vascular Surgery (2086S0129X)	\$26,205	\$14,120	\$18,524	\$40,915	\$25,791	\$16,622
Taxi (344600000X)	\$36,725	\$18,864	\$90	--	--	--
Technician/Technologist, Optician (156FX1800X)	\$47,032	\$51,130	\$45,242	\$28,008	\$16,211	\$9,595
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	\$11,947	\$8,685	\$2,685	\$3,792	\$1,859	\$12,385
Unclassified	\$40,885	\$89,626	--	--	--	--
Urology (208800000X)	\$235,121	\$254,932	\$238,451	\$277,257	\$230,343	\$301,701

APPENDIX B: REIMBURSEMENT METHODOLOGY

This section provides a brief overview and recent history of the reimbursement methodology for the service areas discussed in this report.

Table 62. Reimbursement Methodology and History by Service Area

Reimbursement Methodology and History by Service Area

SFY 2020

SFY 2021

SFY 2022

SFY 2023

SFY 2024

SFY 2025

Ambulance - Wyoming Medicaid Administrative Rule Chapter 15, Chapter 3

- Lower of the Medicaid fee schedule or the provider’s usual and customary charge
- Fixed fee schedule for transport
- Mileage and disposable supplies reimbursed separately
- Separate fee schedules for: Basic Life Support (ground), Advanced Life Support (ground), Additional Advanced Life Support (ground), Air Ambulance

No changes

Due to Governor’s budget reductions, reimbursement was reduced by 2.5%

No changes

No changes

No changes

Supplemental payment program approved by CMS, and first payments distributed.

Ambulatory Surgical Center - 43 CFR 447.321 SPA 4.1.19B

- Based on Medicaid’s Outpatient Prospective Payment System (OPPS). Uses Medicare’s relative weights and the Wyoming Medicaid payment method for each service (OPPS status indicator) for each procedure code. Medicaid adopted Medicare’s OPPS status indicators for most services, with some adjustments for Medicaid policies.
- Services are paid based on one of the following (by status indicator): 1) Ambulatory Payment Classification (APC) fee schedule, 2) separate Medicaid fee schedule, or 3) percentage of charges.

No changes

Due to Governor’s budget reductions, reimbursement was reduced by 2.5%

No changes

No changes

No changes

No changes

Behavioral Health - State Plan 4.19B

- Lower of the Medicaid fee schedule or the provider’s usual and customary charge
- Separate fee schedules based on the type of provider

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Behavioral Health - State Plan 4.19B					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider's usual and customary charge - Separate fee schedules based on the type of provider 					
No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes
Care Management Entity - 42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider's usual and customary charge - Reimbursement based on procedure code fee schedule 					
No changes	Beginning 10/01/2020, the CME sends a 278 transaction to Conduent. Conduent uses the 278 files to issue PA numbers for services provided by the CME network providers who utilize the PAs to bill the Medicaid fiscal agent directly. Magellan continues to send an 837P to Conduent for the PMPM payments but doesn't submit FFS claims on behalf of the CME network providers since the change on 10/01/2020.	Rate increase of 2.5% effective 1/1/2022.	FFS Rate Development Study completed.	Payment methodology and waiver renewals informed by SFY 2023 study.	Rate increases to fee schedule, effective 07/01/2024.
Clinic / Center (Children's Developmental Centers) -Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider's usual and customary charge 					
No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Dental - Wyoming State Plan Attachment 4.19B					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider’s usual and customary charge - Adult optional dental services added (effective July 1, 2006) 					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	No changes	Provider manual update to version 5.0	Dental expenditures for both children and adults have increased due to the legislation approved rate increase, effective 4/1/2023	No changes
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies - Wyoming Medicaid Administrative Rule Chapter 11; Chapter 3, Wyoming State Plan Attachment 4.19B-12c					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule, or the provider’s usual and customary charge - Rates based on Medicare’s fee schedule which is updated annually for inflation based on the consumer price index - For procedure codes not on Medicare’s fee schedule, Medicaid considers other states’ rates - Certain DME is manually priced based on the manufacturer’s invoice price, plus a 12.3% add-on, plus shipping and handling - Delivery of DME more than 50 miles roundtrip is reimbursed per mile 					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%. Supplemental budget reductions approved by Legislature.	Codes impacted by the 21st Century CURES Act are set at 97.5% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change	Rate increase due to agency adoption of rural and non-rural methods. Supplemental budget request approved by Legislature.	No changes	No changes
End-Stage Renal Disease - 42 CFR Part 413 Subpart H; State Plan 4.19B					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider’s usual and customary charge - Dialysis services reimbursed at a percentage of billed charges 					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	No changes	Rate changes based upon fee schedule	Updated in 10/2023 to an all-inclusive rate per encounter	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Federally Qualified Health Centers - 42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452,405.2460-405.2472; Wyoming Medicaid Administrative Rule Chapter 37					
<ul style="list-style-type: none"> - Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000 - Based on 100% of a facility’s average costs during SFYs 1999 and 2000 - Rates increase annually for inflation based on Medicare Economic Index (MEI) charges 					
Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increased by 2.1%	Rates changed based on MEI	Rates changed based on MEI	Rates changed based on MEI
Home Health - 42 CFR 484 Subpart E					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider’s usual and customary charge - Per visit rates based on Medicare’s fee schedule 					
Prior authorization suspended in March 2020	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes
Hospice - 42 CFR 418; Wyoming State Statute 42-4-103(a)(xxv)					
<ul style="list-style-type: none"> - Per diem rate based on Medicare’s fee schedule - Rates adjust annually based on Medicare’s adjustments - Rates for services provided to nursing facility residents are 95% of the nursing facility’s per diem rate - Rate for room and board in an inpatient hospice facility not to exceed 50% of the established nursing home room and board rate (effective July 1, 2013) 					
Rates adjusted per Medicare adjustments	Due to Governor’s budget reductions, reimbursement was reduced by 2.5% for hospice in NH.	Rates adjusted per Medicare’s adjustments, NH hospice was increased by 5% for part of SFY 2022.	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments.

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Hospital (Inpatient) - CFR 447 Subpart C Payment; State Plan 4.19B					
<ul style="list-style-type: none"> - Level of Care (LOC) rate per discharge - Per diem rates for rehabilitation with a ventilator and separate rate without a ventilator - Transplant services are reimbursed at 55% of billed charges - Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement - Additional payments: Inpatient hospitals that serve a disproportionate share of low-income individuals receive disproportionate share hospital (DSH) payments, Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital 					
Second year of DRG rates implemented February 1, 2020	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	Implemented Critical Access Hospital (CAH) sub-group within the rate methodology and shifted funding from other sub-groups to CAHs.
Hospital (Outpatient) - CFR 447.321; CFR 447.325; Wyoming Medicaid Administrative Rule Chapter 33					
<ul style="list-style-type: none"> - Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system - Three conversion factors based on hospital type: General acute; Critical access; Children's - Separate fee schedules for: Select DME; Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammography; - Laboratory; Corneal tissue, dental and bone marrow transplant services, new medical devices - Additional payments: Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital 					
Adjusted conversion factors (effective CY 2020): General acute \$45.79 Critical access \$109.66 Children's \$83.59 ASCs \$40.30	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	Adjusted conversion factors (effective calendar year 2022): General Acute \$46.88 Children's Hospital \$84.54 Critical Access \$112.72 ASCs \$41.25	No changes	No changes	No changes
Intermediate Care Facility for Individuals with Intellectual Disabilities (IFCF/IID) - Wyoming Medicaid Administrative Rule Chapter 20					
- Full cost reimbursement method based on previous year cost reports.					
No changes	No changes	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Laboratory - Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3, Wyoming State Plan Attachment 4.19B					
- Lower of the Medicaid fee schedule or the provider’s usual and customary charge					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes
Nursing Facility - W.S. 42-4-104 (c); State Plan- 4.19D; Wyoming Medicaid Administrative Rule Chapter 7					
- Prospective per diem rate with rate components for capital cost, operational cost and direct care costs					
- Additional reimbursement for extraordinary needs determined on a per case basis					
- Additional payments: Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011), - Nursing Facility Gap Payment Program approved in SFY 2017 as a supplemental payment program					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	NF rates were increased by 5% for July 2021 through June 30, 2022 with a break in January	Rate increase	No changes	Rates were increased by 5%, effective July 2024. In CY 2025 Legislative session, this rate increase became a permanent part of the NF budget.
Physician and Other Practitioners - State Plan Amendment 3.1 and 4.19B					
- Lower of the Medicaid fee schedule or the provider’s usual and customary charge					
- Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare’s RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rate					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%. Chiropractic services only allowed for children under EPSDT and clients on Medicare. Dietician service no longer has a threshold limit.	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Prescription Drugs - State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Administrative Rule, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)					
- Effective 04/01/2017, Payment for covered outpatient legend and non-legend drugs will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:					
a) The National Average Drug Acquisition Cost (NADAC) of the drug; b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%; c) The Federal Upper Limit (FUL); d) The State Maximum Allowable Cost (SMAC); e) The Ingredient Cost submitted; f) The Gross Amount Due (GAD); or g) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.					
- Reimbursement for claims that pay at GAD or U&C will not include a \$10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.					
No changes	No changes	No changes	No changes	No changes	No changes
Program for All-Inclusive Care of the Elderly (PACE) - State Plan Amendment 3.1-A					
- Reimbursement made on a per diem rate, based on an all-inclusive payment methodology					
- Per diem rates are based on the participant's functional assessment					
Rate decreased	Program was discontinued January 2021 due to budget cuts	N/A	N/A	N/A	N/A
Psychiatric Residential Treatment Facility (PRTF) - Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B					
- Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services.					
No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	Rate increase	Rate increase
Public Health or Welfare - Wyoming State Plan Attachment 3.1-A					
- Lower of the Medicaid fee schedule or the provider's usual and customary charge					
No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Public Health, Federal - Public Health Service Act, Sections 321(a) and 322(b); Public Law 83-568; Indian Health Care Improvement Act					
- Indian Health Service (IHS) encounter rate set annually by IHS.					
IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations
Rural Health Center -42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Wyoming Medicaid Administrative Rule Chapter 37					
- Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000					
- Based on 100% of a facility’s average costs during SFYs 1999 and 2000					
- Rates increased annually for inflation based on Medicare Economic Index (MEI)					
Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increased by 2.1%	Rate changes based upon fee schedule	No changes	No changes
Vision - State Plan 3.1-A; State Plan 4.19B/6.b					
- Lower of the Medicaid fee schedule or the provider’s usual and customary charge. The most recent update was in SFY 2006 when the rate for standard frames was increased.					
- Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare’s RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.					
- Optician reimbursement based on a procedure code fee schedule					
No changes	Due to Governor’s budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
<p>Waivers (Comprehensive & Supports) - Required to rebase the rates and conduct rate studies every 2 -4 years per Wyoming Statute Wyo. Stat. § 42-4-120(g)</p> <ul style="list-style-type: none"> - Implemented in SFY 2014 with reimbursement based on the cost-based reimbursement methodology implemented in SFY 2009, but with the reductions made in SFY 2011 and SFY 2014 applied. - The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. - Reimbursement for services is made on a daily or 15-minute unit, with costs determined by a rate buildup based on Wyoming and national service and expenditure data. - For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the funding to meet the participant’s assessed needs. 					
<p>In response to the COVID-19 public health emergency, provider rates for most Comprehensive and Supports Waiver Services were increased, beginning March 1, 2020. The temporary increase ends September 1, 2020.</p>	<p>Effective February 1, 2021, all rates were decreased by 2.5% as a result of budget reductions.</p>	<p>As a result of the ARPA new provider reimbursement rates went into effect on 02/01/2022. This total fully funded the previous rate study, focusing on those services that were excluded from previous legislative action. Providers must apply the entirety of rate increases to direct support worker compensation. These rates are being paid through the enhanced funding made available through ARPA and will sunset on 03/31/2024, unless permanent funding is appropriated by the Wyoming Legislature. Additional increases were passed specifically for costs associated with agency providers.</p>	<p>12.5% temporary rate increase funded through ARPA in effect until 3/31/2025.</p>	<p>12.5% temporary rate increase funded through ARPA in effect until 3/31/2025.</p>	<p>No changes</p>

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Waivers (Community Choices) - Waiver Agreement Appendix I.2.a; Appendix K COVID-19 Addendum					
<ul style="list-style-type: none"> - Long-Term Care services are paid lower than the Medicaid fee schedule or the provider’s usual and customary (U&C) charge with reimbursement limited to a monthly or yearly cap per person, according to their established care plan. - For Assisted Living services, reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem rates are based on the participant’s functional assessment. Per diem rate includes required personal care, 24-hour supervision, and medication assistance up to a monthly or yearly cap. Case management services are reimbursed at a separate rate. Participants pay their own room and board. 					
Rates for select direct care services increased in response to COVID-19 public health emergency	COVID increased continued through SFY 2021	<p>A rate rebasing study was finalized in November 2020, and new provider reimbursement rates went into effect on July 1, 2021.</p> <p>Due to requirements established as part of the American Rescue Plan Act of 2021 (ARPA), case management rates and assisted living facility rates were retroactively adjusted to ensure these rates were not less than the rates that were effective as of April 1, 2021.</p>	Rate increase as agency adopted an increase and hot and cold meals for recipients	12.5% temporary rate maintained, funded through ARPA in effect until 3/31/2025	No changes
Waivers (Children's Mental Health) - 42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider’s usual and customary charge - Reimbursement based on procedure code fee schedule 					
No changes	No changes	No changes	No changes	No changes	No changes

Table 62. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Waivers (Pregnant by Choice) - 11-W-00238/8 (Demonstration Project Number).					
<ul style="list-style-type: none"> - Lower of the Medicaid fee schedule or the provider's usual and customary charge - Reimbursement based on procedure code fee schedule 					
No changes	<p>We completed an extension application for Family Planning Waiver Services that was approved 4/7/2020 to cover FPW services through 12/31/2027. CMS will reimburse by a PMPM amount that varies depending on calendar year. For SFY2021 (07/01/2021 - 06/30/2022), the rate would be \$12.10 (7/1/2021-12/31/2021) and \$12.65 (1/1/2022-6/30/2022). Expenses beyond the PMPM would be covered at Wyoming Medicaid's expense.</p>	No changes	No changes	No changes	No changes

APPENDIX C: ELIGIBILITY REQUIREMENTS & BENEFITS

Table 63. Income Limits by Eligibility Category

Eligibility Category	Income
Children 0-5	154% FPL
Children 6-18	133% FPL
CHIP	200% FPL
Former Foster Care Children, age 19 to 26	No income test
Family Care Adults	Values in Table 73
Pregnant Women	154% FPL
ABD Waivers and Institutions	Less than or equal to 300% SSI
SSI and SSI-Related Coverage Groups	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	120% FPL
Qualified Individual	135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL
Tuberculosis	100% SSI
Employed Individuals with Disabilities	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	Depends on eligibility group qualified under

Table 64. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	2025			
		Family Size 1	2	3	4
CHIP	200%	\$2,609	\$3,525	\$4,442	\$5,359
Family Care Adults	-	\$529	\$737	\$873	\$999
Federal Poverty Level (FPL)	100%	\$1,304	\$1,763	\$2,221	\$2,679
	133%	\$1,735	\$2,345	\$2,954	\$3,564
	154%	\$2,009	\$2,715	\$3,421	\$4,126
Supplementary Security Income (SSI)	100%	\$967	\$1,450	--	--
	300%	\$2,901	--	--	--

Table 65. Eligibility Requirements

Category Group	Eligibility Category	Benefits	Eligibility Requirements	Countable Income	Income Level	Resource Limits
Children	Newborn	Full Medicaid Coverage	Newborns up to age one, with Medicaid-eligible mothers	N/A; eligibility determined by mother's Medicaid eligibility		-
	Children Age 0 -5	Full Medicaid Coverage	Under age six	Countable family income	Less than or equal to 154% of FPL	-
	Children Age 6 -18	Full Medicaid Coverage	Under age 19	Countable family income	Less than or equal to 133% of FPL	-
	Foster Care	Full Medicaid Coverage	Under age 21, in DFS custody	Requirements vary by type of foster care coverage		-
	Subsidized Adoption	Full Medicaid Coverage	Under age 18; under age 21 for children with special needs	Requirements vary by type of foster care coverage		-
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 154% of FPL	-
	Presumptive Eligibility	Outpatient Services for a Limited Time	Pregnant	Countable family income	Less than or equal to 154% of FPL	-
	Pregnant by Choice	Family Planning Services	Enrolled in the Pregnant Women program, within 12 months post-partum	Countable family income	Less than or equal to 159% of FPL	-
Family Care	Family Care	Full Medicaid Coverage	Adult with eligible child under age 18 living in the household	Countable family income	Less than or equal to Family Care Income Standard	-
	Family Care 4 & 12 Month (Extended Medical)	Full Medicaid Coverage	Adult with eligible child under age 18 living in the household; Family unit must have received family care benefits for at least three of the previous 6 months	Countable family income	Exceeds the family care income standard due to increased income due to increased employment, increased earnings, parent returning to work, or spousal support	-
	Former Foster Care	Full Medicaid Coverage	Under age 26	Client has to have been in DFS (Dept of Family Services) custody and on a Federally Funded Foster Care program age 18 or older		-

Category Group	Eligibility Category	Benefits	Eligibility Requirements	Countable Income	Income Level	Resource Limits
Aged, Blind, or Disabled (ABD)	ABD Individuals in Institutions	Full Medicaid Coverage	Age 65 or older; or blind by SSA standards; or disabled by SSA standards; and in an institutional setting, such as nursing home, IMD, hospice care, inpatient hospital, or ICF-IID	Countable personal income	Less than or equal to 300 percent of the SSI payment standard for a single individual	Yes
	Categories w/ Eligibility Determined by Social Security Administration (SSA)	Full Medicaid Coverage	SSI eligibility or SSI-related eligibility. Goldberg Kelly, 1619, Window Widowers SDX, and most DAC cases are all determined by SSA.	Countable personal and spousal income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard	Yes
	SSI-Related Categories w/ Eligibility Determined by WDH	Full Medicaid Coverage	Lost SSI due to increase or receipt of Social Security benefits; disregard increase or SSA benefit amount	Countable personal income	Countable income less than or equal to Monthly SSI Payment Standard	Yes
Medicare Savings Program	Qualified Medicare Beneficiary (QMB)	Medicaid covers Medicare Part A/B premiums CMS may assist with Medicare Part D premiums Medical deductible and coinsurance payments	Entitled to Medicare Part A or Part B	Countable personal and spousal income	Less than or equal to 100% of FPL	Yes
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays Medicare Part B premiums	Entitled to Medicare Part B	Countable personal and spousal income	Between 101% and 120% of FPL	Yes
	Qualified Individuals (QI)	Medicaid pays Medicare Part B premiums (100% federal funds)	Entitled to Medicare Part B	Countable personal and spousal income	Between 121% and 135% of FPL	-

Category Group	Eligibility Category	Benefits	Eligibility Requirements	Countable Income	Income Level	Resource Limits
Special Groups	Breast and Cervical Cancer	Full Medicaid Coverage	Between age 18 and 65 (if over 65, must not be eligible for Medicare Part B); meet the Cancer and Chronic Disease Prevention unit criteria; no insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B)	Countable personal income	Less than or equal to 250% of FPL	-
	Tuberculosis	Partial benefits related to tuberculosis	Verification of tuberculosis	Countable personal income	SSI Payment Standard	Yes

Medicare Buy-In	Employed Individuals w/ Disabilities	Full Medicaid benefits after payment of premium (7.5% of gross monthly income)	Between age 16 and 64; disabled; employed	Countable personal income	Unearned income less than or equal to 300% of the SSI standard for a single individual, no limit on earned income	-
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APPENDIX D: GLOSSARY & ACRONYMS

GLOSSARY

Table 66. Glossary

Term	Definition
A	
Acquired Brain Injury (ABI)	Damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder.
Affordable Care Act (ACA)	The Patient Protection and Affordable Care Act as well as the Healthcare and Education Reconciliation Act was signed into law in March 2010. These laws are collectively known as the Affordable Care Act legislation and represent a significant overhaul to the healthcare system.
Ambulatory Surgical Center (ASC)	A group to which an outpatient service is assigned in Medicare's prospective payment system for outpatient hospital services. The healthcare common procedure coding system, including certain current procedural terminology codes and descriptors are used to identify and group the services within each APC group. Services within an APC group are comparable clinically and with respect to resource use. A payment rate is established for each APC group.
American Recovery and Reinvestment Act of 2009 (ARRA)	Legislation signed into law in February 2009 in response to the economic crisis. The Act specified funding for a wide range of federal programs, including certain benefits under Medicaid.
APR DRG	All Patient Refined Diagnosis Related Groups is a classification system used to group hospitalized patients based on their 1) Reason for Admission: the primary diagnosis that led to hospitalization, 2) Severity of illness: factors such as complications, co-morbidities, and procedures, and 3) Risk of Mortality: the likelihood of the patient dying during their hospital stay.
Average Wholesale Price (AWP)	The published price for drug products charged by wholesalers to pharmacies.
B	
Basic Life Support	A level of medical care, usually provided by emergency medical service professionals, provided to patients of life-threatening illnesses or injuries until they can be given full medical care. Basic life support consists of essential non-invasive life-saving procedures including CPR, bleeding control, splinting broken bones, artificial ventilation, and basic airway management
Benefits Improvement and Protection Act of 2000 (BIPA)	Legislation signed into law in December 2000 that affects several aspects of Medicare and Medicaid.
C	
Centers for Medicare and Medicaid Services (CMS)	The government agency within the Department of Health and Human Services that administers the Medicare program, and works with states to administer Medicaid. In addition to Medicare and Medicaid, CMS oversees the Children's Health Insurance Program.
Children's Health Insurance Program (CHIP)	A federal-state partnership program to provide free or low-cost health insurance for uninsured children under age 19. The CHIP is intended for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

Cognos	The reporting tool used to extract data from the Medicaid Management Information System (MMIS).
Commission on Accreditation of Rehabilitation Facilities (CARF)	An organization that accredits rehabilitation facilities.
Community Mental Health Center (CMHC)	A community-based healthcare facility that provides comprehensive mental health services to individuals residing or employed in the facility service area.
Comprehensive Outpatient Rehabilitation Facility (CORF)	A facility that provides coordinated, comprehensive outpatient rehabilitation services under the supervision of a physician. At a minimum, a CORF must provide physician supervision and physical therapy and social or psychological services to be certified as a CORF.
Co-payment	A fixed amount of money paid by the enrolled member at the time of service.
Council on Accreditation	An organization that accredits healthcare organizations.
Crossover Claim	Services for Medicaid and Medicare dual individuals in which Medicare is the primary payer and forwards the claim to Medicaid for additional payments.
Current Procedural Terminology (CPT)	A code set developed by the American Medical Association for standardizing the terminology and coding used to report medical procedures and services. CPT codes are Level I of the HCPCS code set.
D	
Deficit Reduction Act of 2005 (DRA)	Legislation signed into law in February 2006 that affects several aspects of Medicare and Medicaid.
Department of Health and Human Services (HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
Disproportionate Share Hospital (DSH)	Hospitals that serve a significantly disproportionate number of low-income individuals. Eligible hospitals can receive an adjustment payment under Medicaid.
Drug Utilization Review (DUR)	A review utilization of outpatient prescription drugs to determine if recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects.
Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies	Medical equipment and other supplies that are intended to reduce an individual's physical disability and restore the individual to his or her functional level.
Dual Individual	For the purposes of this Report, an individual enrolled in Medicare and Medicaid who is eligible to receive Medicaid services.
E	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	The comprehensive and preventive child health component of Medicaid for individuals under age 21. Medicaid's EPSDT services are operated under the Health Check program. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.
Eligibility	Criteria that establish an individual as qualified to enroll in Medicaid. The federal government establishes minimum eligibility standards and requires states to cover certain population groups. States have the flexibility to cover other population groups within federal guidelines.
Enrollment	A unique count of members enrolled in Medicaid. Enrollment may be reported at a point in time (e.g., as of June 30) or over a time frame (e.g., SFY 2015).

End-Stage Renal Disease (ESRD)	The complete, or almost complete, failure of the kidneys to function. The only treatments for ESRD are dialysis or kidney transplantation.
Estimated Acquisition Cost (EAC)	The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug
Expenditure	Funds or money spent to liquidate an expense regardless of when the service was provided or the expense was incurred.
Explanation of Benefits (EOB)	An itemized statement of services from an insurance company detailing what services were paid for on the behalf of an individual. The EOB informs an individual what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.

F

Federal Fiscal Year (FFY)	The 12-month accounting period, for which the federal government plans its budget, usually running from October 1 through September 30. The FFY is named for the end date of the year (e.g., FFY 2024 ends on September 30, 2024).
Federal Medical Assistance Percentage (FMAP)	The percentage rates used to determine the federal matching funds allocated to the Medicaid program. The FMAP is the portion of the Medicaid program that is paid by the federal government.
Federal Poverty Level (FPL)	The amount of income determined by the Department of Health and Human Services that is needed to provide a minimum for living necessities.
Federal Upper Limit (FUL)	The maximum price pharmacies receive as reimbursement for providing multiple-source generic prescription drugs. The FUL is established by the Centers for Medicare and Medicaid Services in order to achieve savings by taking advantage of current market pricing. Not all drugs have FULs and states may establish reimbursement limits for non-FUL drugs using other pricing methodologies.
Fee Schedule	A complete listing of fees used by health plans to pay medical care professionals.

H

Healthcare Common Procedure Coding System (HCPCS)	A standardized coding system used to report procedures, specific items, equipment, supplies, and services provided in the delivery of healthcare. There are two principal subsystems, Level I and Level II. Level I codes are comprised of CPT codes which are identified by five numeric digits. Level II codes are used primarily to identify equipment, supplies, and services not included in the CPT code set. Level II codes are alphanumeric codes.
Home and Community-Based Services (HCBS)	Care provided in the home and community to individuals eligible for Medicaid. The HCBS programs help the elderly, intellectually disabled, developmentally disabled, and certain other disabled adults.
HCBS Children's Mental Health (CMH) Waiver	A HCBS waiver developed to allow youth with serious emotional disturbances who need mental health treatment to remain in their home communities.
HCBS Community Choices (CC) Waiver	A HCBS waiver allowing participants age 19 and older who require services equivalent to a nursing facility level of care to receive services in an assisted living facility or in their home.
HCBS Comprehensive Waiver	HCBS Waiver that serves individuals throughout the lifespan with ID, DD, and ABI.
HCBS Supports Waiver	A HCBS waiver developed to replace the former DD waivers for people with a developmental disability. Provides more flexible service than the Comprehensive Waiver, but with a lower cap on benefits.

I	
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)	A facility that primarily provides comprehensive and individualized healthcare and rehabilitation services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.
Individualized Budget Amount (IBA)	In the developmental disability and acquired brain injury waiver programs, the amount of funding allocated to each participant based on individual characteristics and his or her service utilization. For the Comprehensive and Supports Waivers, the amount of funding allocated to an individual.
J	
Joint Commission	An organization that accredits healthcare organizations.
L	
Level of Care (LOC)	Medicaid's prospective payment system for inpatient hospital services. Medicaid reimburses an amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedure, or revenue codes that hospitals report on the inpatient claim.
M	
Medicaid	A joint federal-state program authorized by Title XIX of the Social Security Act that provides medical coverage for certain low-income and other categorically related individuals who meet eligibility requirements. A portion of the Medicaid program is funded by the federal government using the Federal Medical Assistance Percentage.
Medicaid Management Information System (MMIS)	An integrated group of procedures and computer processing operations (subsystems) that supports the Medicaid program operations. The functional areas of the MMIS include recipients, providers, claims processing, reference files, surveillance and utilization review, management and administration reporting, and third-party liability. The MMIS is certified by the Centers for Medicare and Medicaid Services.
Medicare	A federal program, authorized by Title XVIII of the Social Security Act, that provides medical coverage for individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals of all ages with end-stage renal disease.
Medicare Economic Index (MEI)	An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule. Medicaid uses the index as an update factor for FQHC and RHC reimbursement rates.
Member	An individual enrolled in Medicaid and eligible to receive services.
Modified Adjusted Gross Income (MAGI)	A new income methodology implemented in SFY 2013.
P	
Per Member Per Month (PMPM)	The monthly average cost for each enrolled member.
Pharmacy Benefit Management (or Manager) (PBM)	Third-party administrator of prescription drug programs.
Preferred Drug List (PDL)	A list of clinically sound and cost-effective prescription drugs covered by Medicaid that do not require prior authorization.

Pregnant by Choice Waiver	A Section 1115 waiver that provides family planning services and birth control options to women who have received Medicaid benefits under the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth.
Prescription Drug Assistance Program (PDAP)	A state-funded program administered by the Healthcare Financing Division providing up to three prescriptions per month to Wyoming residents with income at or below 100 percent of the FPL.
Prior Authorization (PA)	The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.
Procedure Code	The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.
Psychiatric Residential Treatment Facility (PRTF)	The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.
Q	
Qualified Rate Adjustment (QRA)	Medicaid's annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. The QRA payments are only available to in-state hospitals for inpatient and outpatient services.
R	
Recipient	For the purposes of this Report, an individual enrolled in Medicaid who received Medicaid services.
Resource Based Relative Value Scale (RBRVS)	Established as part of the Omnibus Reconciliation Act of 1989, Medicare's payment principles for physician services were adjusted by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor, and a conversion factor. Procedures are assigned a relative value which is adjusted by geographic region. This value is then multiplied by a conversion factor to determine the amount of payment.
Rural Health Clinic (RHC)	Established as part of the Omnibus Reconciliation Act of 1989, Medicare's payment principles for physician services were adjusted by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor, and a conversion factor. Procedures are assigned a relative value which is adjusted by geographic region. This value is then multiplied by a conversion factor to determine the amount of payment.
S	
Section 1115 Waiver	An experimental, pilot, or demonstration project authorized by Section 1115 of the Social Security Act. Section 1115 projects allow states the flexibility to test new or existing approaches to financing and delivering the Medicaid program.
Social Security Act	The legislation, signed in 1965 that authorized Medicare under Title XVIII, and Medicaid under Title XIX.
State Fiscal Year (SFY)	The 12-month accounting period for which the state plans its budget, usually running from July 1 through June 30. The SFY is named for the end date of the year (e.g., SFY 2024 ends on June 30, 2024).
State Funds	For the purposes of this Report, funds that do not receive any Medicaid Federal Medical Assistance Percentage.

State Maximum Allowable Cost (SMAC)	The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic prescription drugs. Medicaid may include more drugs than what are covered under the federal upper limit program as well as set reimbursement rates that are lower than federal upper limit rates.
Supplemental Security Income (SSI)	A federal income supplement program administered by the Social Security Administration. It is designed to assist the aged, blind, or disabled individuals who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.
T	
Third-Party Liability (TPL)	The legal obligation of a third party to pay part or all of the expenditures for medical assistance under Medicaid.
U	
Usual and Customary Charge	The fee that is most consistently charged by a healthcare provider for a particular procedure. The actual price that pharmacies charge cash-paying customers for prescription drugs.

ACRONYMS

Table 67. Acronyms

Acronym	Meaning	Acronym	Meaning
ABD	Aged, Blind, or Disabled	ABI	Acquired Brain Injury
ACA	Affordable Care Act	ALF	Assisted Living Facility
APC	Ambulatory Payment Classification	ARRA	American Recovery and Reinvestment Act of 2009
ASC	Ambulatory Surgery Center	AWP	Average Wholesale Price
BHD	Behavioral Health Division	BIPA	Benefits Improvement and Protection Act of 2000
CARF	Commission on Accreditation of Rehabilitation Facilities	CCD	Continuity of Care Document
CHIP	Children's Health Insurance Program	CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CME	Care Management Entity	CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services	COA	Council on Accreditation of Services for Families and Children
CORF	Comprehensive Outpatient Rehabilitation Facility	CPT	Current Procedural Terminology
CQM	Clinical Quality Measures	DD	Developmental Disabilities
DFS	Department of Family Services	DME	Durable Medical Equipment
DRA	Deficit Reduction Act	DSH	Disproportionate Share Hospital
DRG	Diagnosis Related Groups	DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost	EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment	ESRD	End-Stage Renal Disease

FFY	Federal Fiscal Year	FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level	FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit	HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System	HHS	Department of Health and Human Services
HIE	Health Information Exchange	HIT	Health Information Exchange
HPSA	Health Professional Shortage Area	IBA	Individualized Budget Amount
LEP	Limited English Proficiency	LOC	Level of Care
LTC	Long-Term Care	MAGI	Modified Adjusted Gross Income
MEI	Medicare Economic Index	MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System	MU	Meaningful Use
NAMFCU	National Association of Medicaid Fraud Control Units	NPI	National Provider Identifier
OIG	Office of Inspector General	OPPS	Outpatient Prospective Payment System
OSCR	On-Site Compliance Review	P&T	Pharmacy and Therapeutics
PA	Prior Authorization	PAB	Psychiatrist Advisory Board
PACE	Program of All-Inclusive Care for the Elderly	PBM	Pharmacy Benefit Management (or Manager)
PCMH	Patient-Centered Medical Home	PDAP	Prescription Drug Assistance Program
PDL	Preferred Drug List	PMPM	Per Member Per Month
POS	Prosthetics, Orthotics, and Supplies	PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility	QIS	Quality Improvement Strategy
QMB	Qualified Medicare Beneficiaries	QRA	Qualified Rate Adjustment
RBRVS	Resource-Based Relative Value Scale	RHC	Rural Health Clinic
RIBN	Resource Integration into Behavioral Health Networks	SLMB	Specified Low-Income Medicare Beneficiaries
SFY	State Fiscal Year	SSA	Social Security Administration
SMAC	State Maximum Allowable Cost	SSI	Supplemental Security Income
SSDC	Sovereign States Drug Consortium	THR	Total Health Record
TB	Tuberculosis	WDH	Wyoming Department of Health
TPL	Third-Party Liability	WES	Wyoming Eligibility System

APPENDIX E: DATA METHODOLOGY

ENROLLMENT

ENROLLMENTS

- A member is any individual enrolled in Medicaid, identified by a Medicaid ID number.
- Enrollment is a distinct count of Medicaid members based on ID number. Members are enrolled in an eligibility program code, which defines the eligibility categories.
- See tables for the eligibility category breakdown by program codes.
- Monthly average of enrollment is calculated using the distinct count of members as of the last day of each month.
- Total SFY enrollment is a distinct count of all members enrolled at any time during the SFY, regardless of the duration of their enrollment span.

RECIPIENTS

- A recipient is any enrolled member who has received services and had a Medicaid claim processed and paid during the SFY.
- Since the distinct count of recipients is based on claims paid during the SFY, this count may exceed enrollment as some recipients may not have maintained enrollment in the SFY in which their claim paid.

EXPENDITURES

- Expenditures represent claim payments made to providers during the SFY. For this report, expenditures include all paid claims, including those that were adjusted and re-adjusted during the SFY.
- Third-party payments, co-payments, DSH payments, and history-only adjustments are excluded from totals, as are premium and cost-sharing assistance for Medicare individuals

PER MEMBER PER MONTH

- The Per Member Per Month (PMPM) represents the monthly average cost for each enrolled member.
- The calculation is equal to expenditures divided by member months in which expenditures are based on original and final adjusted claims by first service dates and member months is the sum of the number of months individuals are enrolled in Medicaid.
- The PMPM value in this report is a preliminary value only. The final SFY 2025 PMPM value will be available in the separate Wyoming Medicaid Per Member Per Month report.

SERVICES

- Most service areas are defined using pay-to-provider taxonomy codes on claims paid during the SFY. See table 69 for the parameters used for each service and special population in this report.
- Other services may use claim types or the recipient's eligibility program code in addition to the pay-to-provider tax code.

Table 68. Medicaid Program Codes

Medicaid Eligibility Chart		Program Codes
Aged, Blind, Disabled Intellectual/ Developmental Disabilities, and Acquired Brain Injury	W19	SSI Support ABI Waiver Aged > 65
	W20	300% Support ABI Waiver Adult > 21
	W21	300% Support ABI Waiver Aged > 65
Aged, Blind, Disabled Institution	S14	Institutional (Hosp) Aged - Inactive
	S15	Inpatient Hospital 300% Cap > 65
	S34	Institutional (Hosp) Disabled - Inactive
	S35	Inpatient Hospital 300% Cap < 65
	S13	Inpatient - Psych > 65
Aged, Blind, Disabled Long-Term Care	R01	Asst Living Fac Wvr SSI < 65
	R02	Asst Living Fac Wvr 300% < 65
	R03	Asst Living Fac Wvr SSI > 65
	R04	Asst Living Fac Wvr 300% > 65
	S50	Hospice Care > 65
	S51	Hospice Care < 65
	N98	WLTC Temp Services
	S24	LTC Waiver SSI > 65
	S25	LTC Waiver 300% Cap > 65
	S46	LTC Waiver SSI < 65
	S47	LTC Waiver 300% Cap < 65
	N97	NH Temp Services
	S01	NH-SSI & Ssa Blend >65
	S02	NH-SSI & Ssa Blend >65
	S10	Nursing Home SSI >65
	S11	Nursing Home 300% Cap >65
	S17	Retro Medicaid-"Pr" Aged (inactive)
	S18	Retro Medicaid-"Rm" Aged (inactive)
S30	Retro Medicaid-"Pr" Disabled (inactive)	
S32	Nursing Home SSI <65	
S33	Nursing Home 300% Cap <65	
S54	Medicaid Only-No Rm & Brd >65	
S55	Medicaid Only-No Rm & Brd <65	
S90	Retro Medicaid-"Rm" Disabled	
P11	PACE < 65	
P12	PCMR < 65	
P13	PACE SSI Disabled < 65	

Medicaid Eligibility Chart

Program Codes

	P14	PACE Medicare SSI Disabled < 65
	P15	PACE NF < 65
	P16	PACE NF SSI Disabled < 65
	P17	PACE NF Medicare Disabled < 65
	P18	PACE NF Medicare SSI Disable < 65
Aged, Blind, Disabled Long-Term Care	P21	PACE > 65
	P22	PCMR > 65
	P23	PACE SSI Aged > 65
	P24	PACE Medicare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
	P28	PACE NF Mcare SSI Aged > 65
	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Payment
	S31	SSI Eligible <65
	S36	Disabled Adult Child (DAC)
	S37	Goldberg-Kelly
	S39	1619 Disabled
	S40	Aptd Essent. Person Med Only -I
Aged, Blind, Disabled SSI & SSI Related	S48	Zebley >21
	S49	Zebley <21
	S92	Widow-Widowers SDX
	S98	Pseudo SSI Aged (inactive)
	S99	Pseudo SSI Disabled (inactive)
	S09	SSI-Disabled Child Definition
	S16	Pickle >65
	S38	Pickle <65
	S42	Widow-Widowers
	S71	SSI Eligible < 21
	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
Children	A50	AFDC Medicaid (inactive)
	A54	2nd-6mos. Trans Mcaid Child (inactive)
	A56	Alien: 245 (IRCA) Child (inactive)
	A57	Baby <1 Yr, Mother SSI Elig (inactive)

Medicaid Eligibility Chart

Program Codes

	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
Children	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont Childrens Ment Health Wvr < 19
	S95	Childrens Ment Hlth Wvr SSI < 21
	S96	Childrens Ment Hlth Wvr 300% <21
	A51	IV-E Foster Care
	A52	IV-E Adoption
	A85	Foster Care Title 19
	A86	Subsidized Adoption Title 19
	A88	Aging Out Foster Care
	A97	Foster Care 0 Through 5
	A98	Foster Care 6 Through 18
	M09	Former Foster Youth <21
	M17	Former Foster Youth PE <21
	S63	Continuous Foster Care <19
	A53	Newborn
	P07	CHIPRA CME
Medicare Savings Programs	S43	Qual Disabled Working Ind
	Q17	QMB > 65
	Q41	QMB < 65

Medicaid Eligibility Chart	Program Codes	
Medicare Savings Programs	Q66	QMB Dual with Full Medicaid
	Q94	SLMB 2 > 65
	Q95	SLMB 2 < 65
	Q96	SLMB 1 > 65
	Q97	SLMB 1 < 65
	Q67	SLMB Dual with Full Medicaid
	Q98	Part B-Partial Aged (Inactive)
	Q99	Part B-Partial Disabled (Inactive)
Non-Citizens with Medical Emergencies	A81	Emergency Service < 21
	A84	Emergency Service > 21
Pregnant Women	A71	Pregnant Woman < 21
	A72	Pregnant Woman > 21
	A73	Qualified Pregnant Woman > 21
	A74	Qualified Pregnant Woman < 21
	M06	Pregnancy MAGI > 21
	M07	Pregnancy MAGI < 21
	A19	Presumptive Eligibility
	B03	Breast & Cervical > 21
	B04	Breast & Cervical < 21
	M15	Breast & Cervical PE > 21
	M16	Breast & Cervical PE < 21
	S52	Tuberculosis (Tb) > 65
	S53	Tuberculosis (Tb) < 65
	A20	Pregnant By Choice
	D99	Targeted Case Management on Waitlist
Screenings & Gross Adjustments	X01	Beneficiary Monitoring Program
	X02	Incarcerated Medicaid Member
	N96	Disability Determination Only
	N99	LTC Screening Only
	W98	Single Day Waiver Assessment - Support
	W99	Single Day Waiver Assessment
	S97	CASII Screening Only
	ZZZ	Other

Table 69. Chart B Program Codes

Chart B Eligibility Chart		Program Codes
	A95	Pending Foster Care
State-Funded Foster Care	A96	Basic Foster Care
	A99	Institutional Foster Care

Table 70. CHIP Program Codes

CHIP Eligibility Chart		Program Codes
	K01	CHIP - A
	K02	CHIP - B
CHIP	K04	CHIP - C
	K05	CHIP - A PE
	K06	CHIP - B & C PE

DATA PARAMETERS

As stated in the previous section, Expenditures are calculated using all Medicaid Chart A recipient program codes and all claim adjustments except history-only adjustments. Counts exclude several program codes and only include original and final claims.

Table 71. Data Parameters by Service Area

Service Area	Pay-to-Provider Taxonomy	Other Parameters
Ambulance - Total	341600000X	Ambulance n/a
Ambulance - Air	341600000X	Ambulance Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998
Ambulance - Ground	341600000X	Ambulance Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998
Ambulatory - Surgery Center	261QA1903X	Ambulatory Surgery Center n/a
Behavioral Health	101Y00000X	Professional Counselor; Certified Mental Health Worker
	101YA0400X	Addictions Therapist/Practitioner
	101YP2500X	Professional Counselor
	103G00000X	Neuropsychologist
	103K00000X	Behavior Analyst
	103TC0700X	Clinical Psychologist
	1041C0700X	Social Worker
	106E00000X	Assistant Behavior Analyst
	106H00000X	Marriage and Family Therapist
	106S00000X	Behavior Technician
	163W00000X	RN
	164W00000X	LPN
	171M00000X	Case Worker
	172V00000X	Community Health Worker; Peer Specialist; Certified
	2084P0800X	Psychiatrist
261QM0801X	Mental Health - including Community Mental Health Center	
261QR0405X	Rehabilitation, Substance Use Disorder	
364SP0808X	NP, APN Psychiatric/Mental Health	

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Behavioral Health services provided by Non-BH providers	EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal		Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125 99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider Claim Types: EXCLUDE W (waiver)
Care Management Entity	251S00000X	CHPR CME	n/a
Clinic/Center (Developmental Centers)	261Q00000X	Clinic/Center	n/a
Dental	122300000X	Dentist	n/a
	1223D0001X	Dental Public Health	
	1223E0200X	Endodontics	
	1223G0001X	General Practice Dentist	
	1223P0221X	Pedodontics	
	1223P0300X	Periodontics	
	1223S0112X	Surgery, Oral and Maxillofacial	
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	1223X0400X	Orthodontics	
	332B00000X	DME	n/a
	332S00000X	Hearing Aid Equipment	
335E00000X	POS		
Durable Medical Equipment Only	332B00000X	DME	n/a
	332S00000X	Hearing Aid Equipment	
Prosthetics, Orthotics, and Supplies Only	335E00000X	POS	n/a
End-Stage Renal Disease	261QE0700X	End-Stage Renal Disease	n/a
Federally Qualified Health Center	261QF0400X	Federally Qualified Health Center	n/a
Home Health	251E00000X	Home Health	n/a
Hospice	251G00000X	Hospice Care, Community-Based	n/a
Hospital Total	261QR0400X	Rehabilitation	n/a
	282N00000X	General Acute Care Hospital	
	282NR1301X	General Acute Care Hospital - Rural	
	283Q00000X	Psychiatric Hospital	
	283X00000X	Rehabilitation Hospital	

Service Area		Pay-to-Provider Taxonomy	Other Parameters
Hospital Inpatient	282N00000X	General Acute Care Hospital	Claim Type: I, X
	282NR1301X	General Acute Care Hospital - Rural	
	283Q00000X	Psychiatric Hospital	
	283X00000X	Rehabilitation Hospital	
Hospital Outpatient	261QR0400X	Rehabilitation	Claim Type: O, V
	282N00000X	General Acute Care Hospital	
	282NR1301X	General Acute Care Hospital - Rural	
	283X00000X	Rehabilitation Hospital	
Hotel Emergency Room	All Taxonomies	Procedure Codes: 99281 - 99285 OR Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (2020 HEDIS) OR Revenue Code: 0450 - 0459 Counts: Claim Type O Expenditures: Header level amounts for all events that have both Medical and Outpatient claim (i.e. no associated inpatient admission)	
International Care Facility for Individuals with Intellectual Disabilities	315P00000X	Intermediate Care Facility, Intellectual Disability	n/a
Laboratory	291U00000X	Clinical Medical Laboratory	n/a
Nursing Facility	275N00000X	Medicare Defined Swing Bed	n/a
	314000000X	Skilled Nursing Facility	
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a
All Taxonomies starting with '20'			
Physician and Other Practitioner Total	363A00000X	Physician Assistant	n/a
	225X00000X	Occupational Therapist	
	225100000X	Physical Therapist	
	213E00000X	Podiatrist	

Service Area	Pay-to-Provider Taxonomy	Other Parameters	
Physician and Other Practitioner Total	363L00000X	Nurse Practitioner	
	363LA2200X		
	363LF0000X		
	363LG0600X		
	363LX0001X		
	363LP0200X		n/a
	367A00000X		Nurse Midwife
	367500000X		Nurse Anesthetist
	231H00000X		Audiologist
235Z00000X	Speech-Language Pathologist		
Physician	All Taxonomies starting with '20'	Psychiatrists	n/a
	EXCLUDING 2084P0800X		
Other Practitioner	363A00000X	Physician Assistant	
	225X00000X	Occupational Therapist	
	225100000X	Physical Therapist	
	213E00000X	Podiatrist	
	363L00000X		
	363LA2200X		
	363LF0000X		
	363LG0600X	Nurse Practitioner	n/a
	363LX0001X		
	363LP0200X		
	367A00000X	Nurse Midwife	
	367500000X	Nurse Anesthetist	
	231H00000X	Audiologist	
235Z00000X	Speech-Language Pathologist		
Prescription Drug	333600000X	Pharmacy	Claim Type: P
Psychiatric Residential Treatment Facility	323P00000X	Psychiatric Residential Treatment Facility	Claim Types: I, X
Public Health, Federal	261QP0904X	Public Health, Federal	n/a
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Vision	152W00000X	Optometrist	n/a
	156FX1800X	Optician	
Waiver - HCBS Waivers - Waiver Only Services	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
	251C00000X	Day Training, DD	
	251X00000X	PACE PPL	
Waiver - HCBS Waivers - Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X, 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - Acquired Brain Injury Waiver Only	251C00000X	Day Training, DD	Claim Type: W, G
	251X00000X	PACE PPL	Recipient Program Codes: B01, B02, S60
Waiver - Acquired Brain Injury Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60
Waiver - Adult with ID/DD Waiver Only	251C00000X	Day Training, DD	Claim Type: W, G
	251X00000X	PACE PPL	Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Adult with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251S00000X	CHPR CME	Claim Type: W, G Recipient Program Codes: S95, S96, S65

Service Area		Pay-to-Provider Taxonomy	Other Parameters
Waiver - Children's Mental Health Non-Waiver Services	251S00000X	Community / Behavioral Health	Recipient Program Codes: S95, S96, S65
	251C00000X	Day Training, DD	Claim Type: W, G
Waiver Comprehensive Waiver Only	251X00000X	PACE PPL	Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver Comprehensive Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X
Waiver - Community Choices Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04
Waiver - Community Choices Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X
Waiver - Pregnant by Choice	All Taxonomies		Recipient Program Code: A20
Waiver - Supports Waiver Only	251C00000X	Day Training, DD	Claim Type: W, G Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21
Waiver - Supports Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21

Table 72. Data Parameters for Subprograms and Special Populations

Subprogram / Special Population	Parameters
Crossover Claims	Claim Type: B, V, X
Foster Care - Medicaid	Recipient Program Codes: A51, A52, A85, A86, A88, A97, A98, S63
Foster Care - State Funded	Recipient Program Codes: A99, A96

